

OAC 5122-29-09 Residential & Withdrawal Management Substance Use Disorder Services**Revised Rule Effective July 1, 2023****Staffing****Who can serve in the role of a clinical program manager as defined in OAC 5122-29-09 (L)(2) and (M)(2) Have an appropriately credentialed, licensed addictions clinician manage the program?**

OhioMHAS consulted with the Ohio Chemical Dependency Professionals Board, the Ohio Counselor, Social Worker, and Marriage & Family Therapist Board and the Ohio Board of Nursing.

A LICDC meets the rule requirement. An LCDC III can serve as the clinical program manager as long as they are under supervision as required in scope. As long as the LCDC III is being supervised, then they have it within their scope to perform the duties of a clinical program manager (assuming they practice within all other aspects of their scope). An LCDC III, under supervision, may carry some of the management burden.

An LPCC, LISW, or IMFT with a declared scope of practice meets the rule requirement. An LSW, LPC, or MFT must work under supervision when engaged in clinical practice, therefore they cannot act as the supervisor of other clinical staff. They could act as a supervisor in an administrative capacity, i.e. approving leave, schedules, etc. However, that does not appear to be applicable in this situation.

A RN has a subset of skills to perform the clinical program manager role. An RN can understand and provide the nursing care needs of an individual with SUD. There are specialty certifications for nurses to engage in such as addiction medicine but is not required by Ohio Board of Nursing. A qualified RN could do this role. The OBN would prefer to see an RN who has an additional amount of professional skills, such as one who has practiced or has knowledge in addiction specialty. A LPN cannot fulfill the clinical program manager role. An LPN would not have licensed authority to do everything they need to do as clinical program manager and it would be beyond their scope of practice.

Who can be the sole person onsite during the day or on-call at night under supervision to meet the requirement in OAC 5122-29-09 (L)(3), (M)(3), and (N)(2)?

OhioMHAS consulted with the Ohio Chemical Dependency Professionals Board, the Ohio Counselor, Social Worker, and Marriage & Family Therapist Board, and the Ohio Board of Nursing.

For a CDCA or LCDCCI to be the sole person during the day or overnight their scope requires supervision of a supervisor to be "readily available". The Ohio Chemical Dependency Professionals Board (OCDP) further stated anyone with a treatment credential from the OCDP Board should be considered to be the qualified person on site and described in the rule, provided that there is access to an appropriately licensed supervisor at all times.

An LPCC, LISW, or IMFT with a declared scope of practice meets the rule requirement. An SWA, LPC, LSW, or MFT with a declared scope of practice and under supervision meets the rule requirement. Access to supervision can be via phone.



A RN has a subset of skills to perform the clinical program manager role. An RN can understand and provide the nursing care needs of an individual with SUD. There are specialty certifications for nurses to engage in such as addiction medicine but is not required by Ohio Board of Nursing. A qualified RN could do this role. The OBN would prefer to see an RN who has an additional amount of professional skills, such as one who has practiced or has knowledge in addiction specialty. A LPN cannot fulfill this requirement. An LPN would not have licensed authority to do everything they need to do according to the rule and it would be beyond their scope of practice.

In OAC 5122-29-09, for ASAM 3.1 level of care, (K)(1) Have a prescriber as part of the interdisciplinary team either through employment or contractual arrangement; however, the prescriber does not provide direct services." What would be considered acceptable to meet this requirement? What is the purpose of having a prescriber as a part of the team or by contractual arrangement?

In the ASAM Criteria, 3rd edition, a prescriber is a required element of the ASAM 3.1 level of care. This includes physicians, advanced practice registered nurses, and physician assistants who review admission decisions to confirm the clinical necessity of service. For ASAM 3.1, they are not required to be involved in direct service provision.

In OAC 5122-29-09, for ASAM 3.2 WM and ASAM 3.5, Section "(M)(3) Have one appropriately certified or licensed addictions clinician on-site days and a certified or licensed practitioner with a declared scope of practice that includes treating people with SUDs in the evenings, with telephonic availability during evenings and nights. A nurse, physician assistant, physician, or emergency services will be available twenty-four hours a day either on site or with telephonic availability." Would someone with an LSW, MSW, LICDC, LCDC III, or LPCC-S qualify as a "licensed practitioner"? For "a nurse, physician assistant, physician, or emergency services will be available twenty-four hours a day" What would satisfy this? Would access to a public emergency service?

OhioMHAS consulted with the Ohio Chemical Dependency Professionals Board and the Counselor, Social Worker, and Marriage & Family Therapist Board. For a CDCA or LCDCII to be the sole person during the day or overnight their scope requires supervision of a supervisor to be "readily available". The Ohio Chemical Dependency Professionals Board (OCDP) further stated anyone with a treatment credential from the OCDP Board should be considered to be the qualified person on site and described in the rule, provided that there is access to an appropriately licensed supervisor at all times.

An LPCC, LISW, or IMFT with a declared scope of practice meets the rule requirement. An SWA, LPC, LSW, or MFT with a declared scope of practice and under supervision meets the rule requirement. Access to supervision can be via phone.

A provider cannot depend on 911 or the public-funded emergency services to meet the rule requirement for emergency services as defined in this rule. A provider can contract or have a memorandum of understanding with a nurse, physician assistant, physician, or other emergency services provider to ensure there is availability 24 hours a day either onsite or with telephonic availability.

Programming & ASAM Level of Care Requirements

In OAC 5122-29-09, for ASAM 3.1 level of care, (K)(2) Offer at least five hours per week of low intensity treatment of substance use disorders, what is "low intensity treatment"?

In the ASAM Criteria, 3rd edition, it states "Level 3.1 programs offer at least 5 hours per week low-intensity treatment of substance related disorders". Treatment is characterized by services such as individual, group, and family therapy; medication management; and psychoeducation.

The services would otherwise meet the specific certified services rules found in OAC 5122-29 for General Services, SUD Case Management, Peer Support Services, Employment Service, Crisis Intervention Service, Referral and Information Service, and Consultation Service. A provider does not need to be certified in each of the specific certified services identified below. These services are all encompassing within SUD residential / withdrawal management service

ASAM 3.1 Co-Occurring Enhanced Programs can provide these additional services

- Mental Health Day Treatment
- Therapeutic Behavioral Services and Psychosocial Rehabilitation
- Community Psychiatric Supportive Treatment

NOTE: In OAC 5122-29-09 (G) Attendance at self-help groups shall not be considered for the purposes of meeting ASAM level of care requirements for services.

In OAC 5122-29-09 for ASAM 3.3 (L)(4) it states "Offer at least thirty hours per week of a combination of skilled treatment services, clinically managed services, and recovery support services focused on individuals where the effects of the substance use or a co-occurring disorder has resulted in cognitive impairment. At least ten of the thirty hours is to include individual, group, or family counseling." What types of services/activities count toward 20 of the 30 hours?

The thirty hours per week of a combination of skilled treatment services, clinically managed services, and recovery support services are services that would otherwise meet the specific certified services rules found in OAC 5122-29 for General Services, SUD Case Management, Peer Support Services, Employment Service, Crisis Intervention Service, Referral and Information Service, and Consultation Service. A provider does not need to be certified in each of the specific certified services identified below. These services are all encompassing within SUD residential / withdrawal management service.

General Services

- At least 10 of the 30 hours are required to be individual, group, or family counseling
- Assessment and Individual Treatment Plan
- Medical & nursing services including medication education
- Psychosocial Educational group (ie. Emotional coping skills, Interpersonal relationship skills building)



- Health education services SUD Case Management
- Promoting re-integration of the individual into the community
- Case management activities directed toward networking patients into community-based ancillary or wrap-around services such as housing, vocational services, transportation assistance
- Development of a social network supportive of recovery
- Education and educational support
- Connection to community colleges
- Financial management
- Vocation connections
- Parenting groups
- Partnerships with local banks to help with bank accounts

Peer Support Services

- Peer Support Services
- Development of a social network supportive of recovery Employment Service
- Vocational rehabilitation services
- Education and educational support
- Connection to community colleges
- Vocation connections

Other Recovery Supportive Services:

- Occupational and recreational therapies by appropriately certified/licensed individuals
- Art, music, or movement therapies by appropriately certified/licensed individuals
- Physical therapy by appropriately certified/licensed individuals

ASAM 3.3 Co-Occurring Enhanced Programs can provide these additional services

- Mental Health Day Treatment
- Therapeutic Behavioral Services and Psychosocial Rehabilitation Community Psychiatric Supportive Treatment

NOTE: In OAC 5122-29-09 (G) Attendance at self-help groups shall not be considered for the purposes of meeting ASAM level of care requirements for services.



In OAC 5122-29-09 for ASAM 3.2 WM and 3.5 (M)(4) Offer at least thirty hours per week of a combination of skilled treatment services, clinically managed services and recovery and withdrawal (for 3.2WM programs) support services focused on individuals who have significant social and psychological problems. At least ten of the thirty hours are to include individual, group, or family counseling.

The thirty hours per week of a combination of skilled treatment services, clinically managed services, and recovery support services are services that would otherwise meet the specific certified services rules found in OAC 5122-29 for General Services, SUD Case Management, Peer Support Services, Employment Service, Crisis Intervention Service, Referral and Information Service, and Consultation Service. A provider does not need to be certified in each of the specific certified services identified below. These services are all encompassing within SUD residential / withdrawal management service.

General Services:

- At least 10 of the 30 hours are required to be individual, group, or family counseling
- Assessment and Individual Treatment Plan
- Medical & nursing services including medication education
- Psychosocial Educational group (ie. Emotional coping skills, Interpersonal relationship skills building)
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- Peer Support Services
- Development of a social network supportive of recovery



Employment Service

- Vocational rehabilitation services
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- Occupational and recreational therapies by appropriately certified/licensed individuals
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ASAM 3.2 WM and 3.5 Co-Occurring Enhanced Programs can provide these additional services

- Mental Health Day Treatment
- Therapeutic Behavioral Services and Psychosocial Rehabilitation
- Community Psychiatric Supportive Treatment

NOTE: In OAC 5122-29-09 (G) Attendance at self-help groups shall not be considered for the purposes of meeting ASAM level of care requirements for services.

OAC 5122-29-09 (I) states “Providers will offer medication assisted treatment onsite or through facilitated access off site”. What are the paths to compliance for providers whose program is an abstinence-based model and/or whose physician does not support the prescribing of MAT?

This is tied to OAC 5122-29-09 (E). A provider must be capable of admitting, initiating, and referring clients receiving medication assisted treatment and capable of facilitating continuity of their pharmacotherapy through care transitions. A provider is required have procedures for ensuring access to all forms of medication assisted treatment (MAT). A provider can meet the OAC requirement by either providing MAT directly or through a memorandum of understanding with another certified/licensed OhioMHAS provider or a healthcare practice that treats patients with FDA approved medications for the treatment of SUD.

Does the use of “in person” in 5122-2909(D)(4) “Provisions for the transition of the client to other SUD treatment providers. Provisions for use of transition communications conducted in person to include staff members of the rendering provider organization, the SUD treatment program to which the patient is being referred, the patient, and family, if present” include provision provided via telehealth? In the OTP rule, face to face means “in person” and can’t be done via telehealth.

In OAC 5122-40-09 (C) it states “Services are allowed to be provided through telehealth pursuant to rule 5122-29-31 of the Administrative Code, and these services are to be documented in accordance with paragraph (G) of rule 5122-2931 of the Administrative Code. Telehealth services including induction of



any form of medication assisted treatment will only be allowed in accordance with federal and state standards.”

In OAC 5122-29-31 (F) “Individuals receiving residential and withdrawal management substance use disorder services as defined in rule 5122-29-09 of the Administrative Code or mental health day treatment service as defined in rule 5122-29-06 of the Administrative Code may receive any of the component services listed in paragraph (E) of this rule through telehealth.

Is there, will there, be guidelines issued for Peer Support Services provided in residential LOC's of SUD treatment? As of July, it will be required, however, how much? How often?

As of July 1, 2023, a provider of SUD residential and withdrawal management substance use disorder services in accordance with OAC 5122-29-09 (L), (M), and (N) must have certified peer supporter(s) as part of the interdisciplinary team as appropriate and available to the range and severity of the residents’ problems.

Peer Support Services provided by a certified peer recovery supporter are counted toward the minimum 30 hours per week of recovery support services required for ASAM 3.2-WM, ASAM 3.3, ASAM 3.5, ASAM 3.7-WM, and ASAM 3.7.

Certified peer supporters are members of the interdisciplinary team.

In OAC 5122-29-09 (K), it says that A Medicaid standard says "Have a prescriber as part of the interdisciplinary team either through employment or contractual arrangement; however, the prescriber does not provide direct services". Can you clarify this? It seems to say you need a prescriber, but they can't actually see the clients and prescribe medication for them.

OAC 5122-29-09 (K) does not prohibit having the prescriber providing services, but rather a reference to having the prescriber as part of the interdisciplinary team whether or not the prescriber renders medical services within the 3.1 facility. ASAM level 3.1, which is the least intensive level of SUD residential treatment, may not require medical treatment patients but they likely would “review admission decisions to confirm clinical necessity of services”.

Can you elaborate on transfer vs. successful completion?

Transfer includes patients who transfer to another level of hospital, residential or outpatient care, such as those who need withdrawal management that was not anticipated. This might also be those who needed a higher or lower level of care than identified at intake.

Successful completion includes patients who have transitioned to the next lower level of care based on attainment of treatment plan goals.

Is there a standard identified of an actual timeframe for when linkage to aftercare upon discharge should take place?

While the rule does not identify a specific timeframe, linkage to aftercare is critical and should occur as part of discharge planning.



Who is the best person to follow-up with the aftercare provider? Peer supported, referring counselor, case manager? So, I am hearing it is not enough to contact the client only to see if they went to aftercare but also the aftercare provider?

Programs have used all of those professionals to do this aftercare follow-up. And you are correct that contacting the provider that is accepting the referral to confirm the individual was able to follow through is a requirement (or at least make an attempt at confirming this with the accepting treatment provider).

What is the ASAM level of care for Crisis Stabilization Unit?

Currently, OhioMHAS does not have a service certification or a designation for a “crisis stabilization unit” in our regulatory framework nor does ASAM have an operating definition for a “crisis stabilization unit” or a specific level of care. If a provider wishes to operate an adult only substance use disorder crisis stabilization unit, the provider will need to be certified in General Services (Ohio Administrative Code 5122-29-03) and Residential and Withdrawal Management substance use disorder services (Ohio Administrative Code 5122-29-09) for either ASAM Level 2-WM, Level 3.2 WM, and/or Level 3.7 WM.

If a provider wishes to operate a youth substance use disorder only crisis stabilization unit, the provider will need to be certified in General Services and Substance Use disorder, Qualified Residential Treatment program (QRTP) (Ohio Administrative Code 5122-29-09.1). If a provider wishes to operate a co-occurring Mental Health & Substance Use disorder crisis stabilization unit, the provider will need to seek licensure as a Residential Class 1 facility (Ohio Administrative Code 5122-30). Additionally, the provider will need to consider certification for the following certified services: general services (Ohio Administrative Code 5122-29-03), SUD case management service (Ohio Administrative Code 5122-29-13), and peer recovery services (Ohio Administrative Code 5122-29-15).

ASAM 3.5 & above require line of sight - Does this include appointments with outside service providers such as medical, dental, court appointments rather than dropping off & picking up. Must we attend the actual appointment with the client?

Reference the ASAM trainings at ASAM eLearning: LOCC Courses. At ASAM level of care 3.5, the patient should be escorted at all times by a staff member including transportation and appointments with outside service providers.

Yes, this would include transportation to medical and court appointments. Having a staff member in attendance can help support the client in a stressful situation including court visits and medical appointments and mitigate leaving against medical/staff advice.

What do you think the staffing ratios should be for 3.7, or 3.5 for both medical and clinical staff?

Please refer to OAC 5122-29-09 (M) and (N) for staffing requirements. The OAC does not identify minimum staff to client ratios.

Are there regulations regarding searches of the person?



There are no specific OAC reference to physical searches in the residential rule, but the facility must adhere to resident rights rules (OAC 5122-26-18) - notably that residents must be treated with consideration and respect for personal dignity, autonomy, and privacy. Providers must be clear that they are not law enforcement and law enforcement invasive physical search tactics should not be employed in a community-based residential setting. The facility should be able to take reasonable steps to ensure contraband is not being brought into the facility.

Can we use scheduled Activity recovery skills as part of the 30 hours of scheduling in a residential setting since we are treating the whole person and it would be part of their treatment plan, as in scheduled recreation time and scheduled exercise time?

Recreation and exercise is an important part of recovery and can be provided outside of the 30 hours.

If the recreation and exercise activities is simply available during the week, the activities cannot be included in the 30 hours of evidenced based treatment required per week.

If a licensed recreation therapist is facilitating recreation and exercise activities, then it can be included in the 30 hours required per week. Intentionality and purpose of the activities as well as therapeutic outcome will be documented in the clinical record for each participating individual.

For 3.5 LOC- "Have a certified or licensed practitioner with a declared scope of practice that includes treating people with SUDs in the evenings" Do we know what "evenings" means- client lights out, or end of the daily programing?

The use of the word "evenings" in the OAC means after normal business hours typically after dinner until bedtime/client lights out.

Of the 30 hours of programing, 10 must be "clinical". Could you define clinical? Is that via licensed staff vs certified.

OAC 5122-29-09 requires at least 10 of the 30 hours of programming per week be individual, group, or family counseling provided by appropriately certified or licensed addictions clinician on-site days and a certified or licensed practitioner with a declared scope of practice that includes treating people with SUDs in the evenings, with telephonic availability during evenings and nights. It is important that the content is clinical in nature and that the notes indicate focus on interventions that promote cognitive change. These hours should be connected to use of an Evidence Based Practice. The staff delivering the services and interventions must be doing so within their scope of practice and with appropriate supervision.

How should we approach individuals seeking treatment that is a part of the transgender community? We have not experienced this often (3 times total in 3 years) but have taken an inclusive approach and it has worked well each time. Is there any specific standards regarding biological sex assigned at birth in a gender specific facility to provide the best possible trauma informed care for all individuals, example a biological male that identifies as female and presents female admitting to a female specific facility.



OAC does not speak to this question specifically. In terms of the transgender in the community, we are seeing spikes in substance use, suicide rates and mental health issues due to all of the things that are happening nationally. This is a hugely vulnerable population that needs a trauma-informed, culturally competent approach. The best practice is to talk with the client very intentionally regarding which unit would help them feel safest. Strongly discourage making decisions for clients based solely on their physical characteristics, and whether or not they have had certain procedures or operations as that can be unintentionally discriminatory as access to those procedures may be cost prohibitive or may not be medically indicated. For the individual, it is very much about that person's preference in that area. We have seen agencies that have specific areas for clients with special medical or mobility needs and for their transgender clients. It is also important to train staff on cultural competency for the LGBTQ and transgender community before you have a transgender client.

Can a youth SUD residential/withdrawal management program (QRTP) serve youth, age 18-21, ie transitional age youth?

OAC does not speak to this question specifically.

The ASAM Criteria 3rd edition defines an adolescent as an individual 13 through 18 or a young adult aged 18 to 21 who may be in need of adolescent-type services rather than adult-type services.

If a QRTP/SUD residential provider wishes to serve a young adult as defined above, the provider will need to submit a waiver request per individual

Does a Peer supporter or a CDCA certified staff member, or a staff who has CMS (Care management Specialist) providing group count toward the 10 clinical hours?

A CDCA can facilitate a SUD clinical group as long as it is within their scope of practice, they are supervised appropriately, AND a supervisor is readily available.

A Care Management Specialist and Qualified Behavioral Health Specialist cannot provide clinical services that require a credential from the OCDP board, OCSWMFT board, Ohio board of Nursing, Ohio Board of Pharmacy, or Ohio Board of Psychology

A Care management specialist (SUD specialty) as defined in ORC 5160-27-01 (A)(6)(b)(iii) can provide SUD Case management.

A Qualified Behavioral Health Specialist (MH only or Co-Occurring MH/SUD specialty) working in an ASAM Level 3.3, Co-Occurring Enhanced Program, as defined in OAC 5122-29-30 (D) can provide the component parts of certified services as defined in Mental health day treatment, SUD case management, community psychiatric supportive treatment, therapeutic behavioral services and psychosocial rehabilitation, and assertive community treatment.

A certified Peer Supporter can provide Peer Support Services as defined in OAC 5122-29-15 and may be facilitated to individuals, families, or groups. Peer Support Services count towards the 30 hours of services but not the 10 hours of clinical treatment.



Medication Assisted Treatment

Wouldn't a youth SUD residential ASAM 3.5 fall under the SAMHSA requirements for MAT - which specifically states that anyone under the age of 18 MUST have 2 failed opiate detox/recovery episodes in the prior year to qualify for MAT & the Medical Director MUST document parental/guardian approval and the clinical benefit of beginning MAT.

No. SUD residential providers are certified as community behavioral health centers not as licensed Opioid Treatment Programs.

The reference of "2 failed opiate detox/recovery episodes" is part of the federal rule for licensed Opioid Treatment Program (OTP) admission criteria. There are pending revisions to the federal law revising the admission criteria.

Please refer to SAMHSA Tip 63: Medications for Opiate Use Disorder. This document provides clinical standards of care for treating opioid use disorder with medications. Standards do not delineate between adult or adolescent patients. It is important to keep in mind the clinical literature that applies to adolescents and the development issues of that stage of life. <https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-DisorderFull-Document/PEP21-02-01-002>

Does a provider have to offer the whole gamut of MAT to be compliant with OAC 5122-29-09 (E) Each provider rendering services pursuant to this rule will be capable of admitting, initiating, and Medication Assisted Treatment (MAT) is a nationally recognized evidence-based practice that improves treatment outcomes for those with alcohol and/or opiate use disorder. A provider must offer access to all forms of medication assisted treatment onsite or through facilitated offsite access (ie a contract with another referring clients receiving medication assisted treatment and capable of facilitating the continuity of their pharmacotherapy through care transitions, including but not limited to other levels of care for behavioral health treatment, hospitals, community-based providers, and criminal justice settings?

Medication Assisted Treatment (MAT) is a nationally recognized evidence-based practice that improves treatment outcomes for those with alcohol and/or opiate use disorder. A provider must offer access to all forms of medication assisted treatment onsite or through facilitated offsite access (ie a contract with another provider) for a client to either begin, maintain, and/or be able to continue with the medication assisted treatment of their choice while in residential SUD treatment.

We've used MAT (not Methadone) in our residential treatment for years and consistently struggle with diversion. I'd be interested in hearing effective strategies that have worked to decrease this other than what we've tried (staff monitoring, use of video surveillance during med pass, ongoing relapse prevention interventions)

There are many ways to help reduce diversion. The first is watching the medication placement under the tongue by staff. Regular use of drug screens is also critical. We also find that when there is high level of diversion, it is important to look at the individual who is receiving the diverted medication to see if they need treatment with a medication themselves.

People who are on M.A.T should be encouraged to stay on as long as possible? So to decrease the risk of overdose. If not, how long should they remain on.??

They should stay on the medication as long as it is continuing to benefit the individual. Unfortunately, there isn't a one size fits all answer, but needs to be individualized for each person as a decision between the prescriber and the patient. Best practice is that the client stays on MAT until they indicate, without suggestion from the provider, that they are ready to taper.

Medication – Self Administration & Storage of Medications

For ASAM 3.1 LOC, what are the requirements for self-administered medications and storing residents' medications?

OAC 5122-26-15: Medication Handling and drug theft provide the regulatory guidance for community behavioral health providers which includes those who are certified for SUD residential and withdrawal management services.

Peer Support Services

Is peer support considered a clinical intervention from the perspective of the state, for the 1115 waiver?

In OAC 5122-29-09, a provider is required to offer at least thirty hours per week of a combination of skilled treatment services, clinically managed services and recovery/withdrawal support services focused on individuals who have significant social and psychological problems.

Peer recovery support services provided by a certified peer recovery supporter can be included in the thirty hours per week

In OAC 5122-29-09, for ASAM 3.2 WM and ASAM 3.5, (M)(1) Include, in addition to the ASAM specified interdisciplinary team members, peer supporters certified pursuant to rule 5122-2915.1 of the Administrative Code as appropriate and available to the range and severity of the residents' problems. How many peer supporters would have to be on staff to meet this requirement?

Certified peer supporters must meet the requirements as defined in OAC 5122-2915.1. Certified peer supporters deliver the certified service of Peer Support Services as defined in OAC 5122-2915. The number of certified peer supporters is determined as appropriate and available to the range and severity of the residents' problems. The program must be intentional about the integration and availability of certified peer supporters in the therapeutic milieu. While the rule is not prescriptive on the number of peers per program, good clinical practice requires an adequate # of certified peer supporters based on the bed capacity of the program.

Is there, will there, be guidelines issued for Peer Support Services provided in residential LOC's of SUD treatment? As of July, it will be required, however, how much? How often?

As of July 1, 2023, a provider of SUD residential and withdrawal management substance use disorder services in accordance with OAC 5122-29-09 (L), (M), and (N) must make available certified peer supporter(s) as part of the



interdisciplinary team as appropriate and available to the range and severity of the residents' problems. Services provided by a certified peer recovery supporter are counted toward the minimum 30 hours per week of a combination of skilled treatment services, clinically managed services and recovery support services required for ASAM 3.2-WM, ASAM 3.3, ASAM 3.5, ASAM 3.7-WM, and ASAM 3.7.

Is peer support considered a clinical intervention from the perspective of the state, for the 1115 waiver?

Services provided by a certified peer supporter count toward the minimum 30 hours of a combination of skilled treatment services, clinically managed services, and recovery support services focused on individuals where the effects of substance use or a co-occurring disorder has resulted in cognitive impairment. Certified peer supporters are part of the interdisciplinary clinical team.

Certified Peer Recovery Supporter

Who do we contact to host a certified peer recovery supporter training?

Up to 18 individuals may join an online PRS training; up to 25 individuals may join an in-person training. Trainings are held at the request of the area mental health and recovery services boards, or board-designated training host.

The calendar of peer support trainings can be found online at: <https://mha.ohio.gov/community-partners/peer-supporters/certified-peer-recovery-supporter-cprs-adult/paths-to-certification/complete-the-ohiomhas-prs-training/complete-the-ohiomhas-40-hour-prs-training/01-ohiomhas-40-hour-prs-training-calendar>

For specific questions, please contact peerservices@mha.ohio.gov

How do you differentiate between a residential aide and a peer support specialist?

A certified peer recovery supporter is someone who has completed the requirements outlined in OAC 5122-29-15.1 who is providing Peer Support Services. A residential aide is someone who is not licensed or certified and who has received training to provide support in the residential setting. This person may be trained as a Qualified Behavioral Health Specialist or Care Management specialist as outlined in OAC 5122-29-30 but it is not required.

Is there a requirement for how long an individual needs to be sober before being able to obtain their certification as a peer supporter?

There is no minimum requirement for sobriety or recovery time needed to pursue peer support certification. The certification requirements for certified peer supporter are in OAC 5122-29-15.1 (F) Certification.

It is a requirement that the individual self-identifies that they are in recovery from a mental health and/or substance use disorder.

What are the requirements for becoming a certified peer supporter?



The certification requirements for certified peer supporter are in OAC 5122-29-15.1 (F):

- To obtain peer supporter certification individuals will submit a complete and compliant application including the following documentation:
 - Proof of a minimum of forty hours of department approved competency-based peer services training or three equivalent years formal, verifiable experience providing behavioral health peers services pursuant to rule 5122-29-15 of the Administrative Code.
 - Hold a high school diploma, a general educational development certification, or similar secondary education from outside of the United States;
 - Documentation of passing the department peer supporter exam, or an exam administered or designated by the department; Certified peer supporters will attest to having read and understood the code of ethics at initial certification and every certification renewal thereafter;
 - The results of a bureau of criminal investigation and federal bureau of investigation criminal records check conducted within one year of submission.
 - For CPRS and CYPS certification, completion of sixteen hours of online learning administered or designated by the department.
- Certifications issued by the department expire two years from the date the certification issued or renewed.

Where would we be able to obtain more information on Supervisor Training for Peers?

The supervision requirements for certified peer supporters and the supervisor requirements are in OAC 5122-29-15.1 (E). Additional information on Supervisor training can be found at <https://mha.ohio.gov/community-partners/peer-supporters/supervising-peer-supporters>

Are there any limits or bottlenecks to how many people can enroll in the training at a given time?

Up to 18 individuals may join an online PRS training; up to 25 individuals may join an in-person training. Trainings are held at the request of the area mental health and recovery services boards, or board-designated training host.

The calendar of peer support trainings can be found online at: <https://mha.ohio.gov/community-partners/peer-supporters/certified-peer-recovery-supporter-cprs-adult/paths-to-certification/complete-the-ohiomhas-prs-training/complete-the-ohiomhas-40-hour-prs-training/01-ohiomhas-40-hour-prs-training-calendar>

Is 2 hours a month the standard for Peer support supervision?

OhioMHAS does not specify in administrative code a required amount of supervision for Peer Supporters – this is per the policy of each agency.



Supervision for peer supporters should echo the policy and practice of supervision of other professionals at the agency/organization.