



Peer Certification Principles for Implementation

As California begins the implementation of peer certification due to enactment of Senate Bill 803 (Beall), the California Alliance of Child & Family Services, the California Association of Social Rehabilitation Agencies and the National Alliance on Mental Illness, California believe that as the current dialogue around what peer providers, family partners and parent partners can, can't or must do continues, it is equally important that the State, the individual county behavioral health systems and private providers undertake a similar process of identifying what they must do to guarantee the successful implementation of peer certification.

Since California is not on the leading edge of the adoption of peer certification, it does come with the potential to benefit from the experience of the dozens of other states that have gone down this path. Added to this is the fact that Peer Providers and peer services have existed within California for decades, creating a wealth of home-grown experience.

We believe that as the Department of Health Care Services embarks on the process of determining peer certification standards and county behavioral health systems begin developing their certification programs, the following principles should be used as guideposts for implementation. They are offered, in no particular order of importance, as all are necessary for successful implementation.

- **Equity in pay and benefits**

Peer providers, family partners and parent partners advocates bring unique and valuable skill sets to the table and should be compensated fairly for their time, effort, and expertise. This will require the establishment of reimbursement rates for peer services in Medi-Cal that are no lower than existing per minute rates for rehabilitative supports/care coordination in order to allow counties and private providers to pay these wages and offer a full range of health and other benefits. This also requires counties to commit to providers to pass through the revenue necessary to cover these costs and for private providers to make a commitment to use that revenue for this purpose. In addition, as DHCS moves forward with the CalAIM process and looks to the opportunities offered in shifting to value-based payments, the value associated with peer services must be recognized and represented in the payment structure(s).

- **Career paths must be readily available, accessible, and promoted**

Although there will be a tendency within behavioral health systems to classify peer provider, family partner and parent partner positions as "entry level", there is no mandate to do so. True integration of peer services into the behavioral health workforce will not only require that peer certification be included as part of designated peer roles, but that possession of certification not limit individuals solely to designated peer roles. In addition, county behavioral health systems and private providers must make commitments to actively recruit, support and train peer providers for supervisory and administrative positions. The creation of viable career ladders/lattice will require county systems to contractually mandate and support their establishment in their private provider networks, and it will also require counties to recognize certification from other counties to facilitate the economic mobility of peer providers, family partners, and parent partners.

- **Clarity in job responsibilities, expectations, and support**

Peer provider, family partner and parent partner positions must have clear job and service descriptions that identify and support their unique and distinct contributions to traditional mental health services while also respecting the needs of their local communities. Vague job descriptions and the overuse of “other duties as assigned” bring with them the danger of marginalization and/or “co-optation” of the peer role, while lack of flexibility in job titles risks alienating those who identify with the role, but not the title. In addition, peer providers, family partners and parent partners should be given equal access to information, technology, and support from their employers. All staff benefit from a supportive work environment, and the inclusion of peers in the workforce offers an opportunity for the behavioral health system to reexamine its supportive structures for all.

- **Distinction between Peer role specializations**

To ensure that the unique skill sets, qualifications and roles of each of the Peer specializations are fully understood and utilized, explicit definitions must be developed and consistently used. Each Peer specialization has unique support and training needs that must be addressed in the development of training and certification standards.

- Adult Peer Support Specialists are persons who are 18 year of age or older and who have self-identified as having lived experience of recovery from mental illness, substance use disorder or both, and the skills learned in formal trainings to deliver peer support services in a behavioral setting to promote mind-body recovery and resiliency for adults.
- Family Peer Support Specialists are persons with lived experience as a self-identified family member of an individual experiencing mental illness, substance use disorder, or both, and have the skills learned in formal trainings to assist and empower families of individuals experiencing mental illness, substance use disorder or both. These Specialists also include siblings, kinship caregivers, and their partners.
- Parent Peer Support provides the most fundamental element of the children’s behavioral health family movement in the last 30 years, since the implementation of Children’s System of Care in California. Families have always intuitively known that sharing information, support and advocacy with one another is a key component to overcoming the challenges of raising and supporting a child/youth with behavioral health care needs. Children’s behavioral health success depends on families who are well supported and knowledgeable about the multiple systems, notably child welfare and juvenile justice, they utilize. It is also important to understand that there is a distinction between the Parent Peer Support provided in Behavioral Health and that provided by Parent Partners in the child welfare and juvenile justice systems.
- Transition Age Youth (TAY) Support Specialists are persons who are 18 years of age or older and who have identified as having lived experience of recovery from mental illness, substance use disorder, or both, and the skills learned in formal trainings to deliver peer support services in a behavioral health setting to promote mind-body recovery and resiliency for transition-age youth, including adolescents and young adults. Training and coaching models centered in a positive youth development framework should be incorporated in state guidelines and training certification standards.

- **Active and ongoing advocacy and support**

The experience of other states indicates that systemic resistance to the inclusion of peer providers is a primary barrier to successful implementation. This resistance is due primarily to a lack of knowledge and understanding about the unique and important roles occupied by peer providers, family partners and parent partners. To counter this, there must be identified champions at the State, county, and private provider levels to demonstrate the commitment of the behavioral health system to support peers and to promote the valuable role of peers. There must be competency-based training for supervisors of peer providers, family partners and parent partners, educational outreach to colleagues and professional associations, as well as those involved in audit and quality assurance functions at all levels.