Research Report

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Early Implementation of California's Peer Support Specialist Certification Program

Perspectives of Clinical Administrators, Peer Support Specialists, and Service Users

In September 2020, California passed the Peer Support Specialist (PSS) Certification Program Act (California Senate Bill [SB] 803), which created a system for training and certifying *peers*, individuals who work in mental health or substance use services and use their own lived experience with treatment and recovery to help others. The general concept that an individual with lived experience can make a unique contribution to the recovery of others has a long history in mental health care (Davidson et al., 2012), and peer support services have been shown to be effective as a stand-alone or adjunct component of behavioral health care (Gaiser et al., 2021). However, the role of PSSs has only recently come to be recognized as an official and routine component of treatment systems in the United States (Ostrow and Adams, 2012). Within Medicaid, which is the largest payer for services for people with serious mental illness, states have the authority to reimburse the work of PSSs as a component of mental health treatment, provided that the peer delivering the service has been certified according to training standards set by the state (Centers for Medicare & Medicaid Services, 2007; Ostrow et al., 2017). In 2001, Georgia became the first state to implement Medicaid billing for peer support services (Landers and Zhou, 2014). With SB 803, California became the 49th U.S. state to implement a peer certification program (Kaufman, Kuhn, and Stevens Manser, 2016; SB 803). Peer support services in participating counties are reimbursed by Medi-Cal (California's Medicaid health care program), and individuals who complete the certification are referred to as Medi-Cal Peer Support Specialists (MPSSs).

Peers are not entirely new to behavioral health services in California. PSSs worked in various capacities in county-run specialty behavioral health systems prior to the passage of SB 803, but the

KEY FINDINGS

- **Respondents value the contributions of Peer Support Specialists (PSSs):** All three groups of respondents (administrators, PSSs, and service users) voiced positive opinions about PSSs, recognizing that they contribute to recovery-oriented services and are distinct from clinical staff. Service users described being made to feel more comfortable in treatment settings and receiving valuable support and life skills from the PSSs with whom they work.
- **Certification improved understandings of the Medi-Cal Peer Support Specialist (MPSS) role:** Administrators and MPSS respondents credited the certification program with providing a greater understanding of the MPSS role among clinical staff and MPSSs alike. The improved understanding of the MPSS role, according to all three groups of respondents, contributed to greater confidence among MPSSs in delivering services.
- **Certification improved integration of MPSSs into clinical teams:** Administrators perceived greater ability to coordinate the work of MPSSs with that of the clinical team, and MPSSs reported increases in job responsibilities, including greater autonomy in managing their caseloads.
- **Certification could improve working conditions and career development for MPSSs:** Views on the impact of certification on careers were mixed. Some MPSSs saw the certification as an important career milestone and a valuable credential for themselves, and some program administrators considered certification an important credential that would influence their decisions in hiring. There were some reports that certification had led to increases in wages. However, other respondents, among both administrators and **MPSSs, emphasized that the certification program has yet to have an influence on MPSSs' careers.**
- **Respondents report it is too early to detect the impact of certification on service user outcomes:** Although respondents acknowledged positive impacts of certification for MPSSs, they were generally in agreement that it is too early to assess the impact of certification on service user outcomes. Some peer support users noticed changes after their MPSS completed the training, such as more-robust skills around goal-setting and communication strategies.
- **Respondents reported barriers to completing the certification process:** MPSSs reported a variety of challenges they encountered while taking the required training and the MPSS certification exam. These challenges included gathering the required documentation, the cost of the training and the test, and stress related to the taking the test.

state lacked consistent standards for training and reimbursement for their services. Consequently, employment of PSSs varied widely across counties. SB 803 required that the Department of Health Care Services (DHCS) establish "statewide requirements for counties or their representatives to use in developing certification programs for the certification of peer support specialists" (SB 803). Along with this, SB 803 gives DHCS the authority to develop specific billing codes and reimbursement schedules for peer support services. SB 803 is not a state mandate: Rather, individual counties can participate in demonstration and pilot programs voluntarily by developing and submitting county-specific certification programs, subject to DHCS approval.

Peer Certification in California

The certification program is still in its early stages of implementation. In July 2021, DHCS released MPSS certification standards for the specialty mental health and substance use disorder delivery systems (known as *County Behavioral Health Plans*). These plans designated the California Mental Health Services Authority (CalMHSA) as the certifying entity. In that capacity, CalMHSA is responsible for implementing and monitoring a statewide training and certification program and assisting county behavioral health plans to meet requirements (DHCS, 2021). MPSS certification began in September 2022. As of January 2024, records show that 55 of 58 California counties have

opted to participate in the DHCS peer benefit, and 2,569 MPSSs have been certified (DHCS, undated).

PSS Certification in California

There is a long history of individuals with lived experience of mental health and/or substance use disorders providing support to their peers in California. Mutual aid groups, such as Alcoholics Anonymous and Narcotics Anonymous, have long relied on nonprofessional peers with lived experience to assist people recovering from substance use disorders. (Alcoholics Anonymous and Narcotics Anonymous chapters were established in California in the1940s and 1950s, respectively; see White, 1998). California's first staff-facilitated peer support program for people with mental illness was established in Los Angeles County in 1979 (Project Return Peer Support Network, undated). Prior to the passage of SB 803, there were PSS training and certification programs available through community colleges and community-based organizations (CBOs), and many counties employed peers in civil service or CBO-contracted positions (Brasher and Dei Rossi, 2012). In the counties that employed PSSs, their work was financed through Medi-Cal by billing PSSs as "other providers," or with non–Medi-Cal funds available to counties (Clafin and Adcock, 2015). In the context of California's decentralized, county-run behavioral health systems, use of peers in behavioral health care varied dramatically across counties. The contribution of SB 803 was to create a unified system for training and certifying peers as PSSs along with specific Medi-Cal billing codes under which services provided by certified MPSSs can be reimbursed statewide.

Introduction of MPSS Certification

As authorized by SB 803, DHCS developed MPSS certification standards and guidelines with input from a statewide workgroup composed of 125 peers, led by the California Association of Mental Health Peer Run Organizations (CAMHPRO). Guided by the outcomes of that process, CalMHSA developed and piloted the MPSS training curriculum and a process for approving vendors to provide the training. To become certified, an applicant is required to take a training program from an approved vendor and pass the certification exam. Initially, a provision was made for an accelerated pathway to certification for individuals who already had extensive experience providing peer support. These individuals were allowed to take the certification exam without taking the new training program, provided they could demonstrate that they had prior training and met all other requirements. This "grandparenting" pathway was available through June 30, 2023. Of the 2,569 MPSSs who have been certified, 1,048 did so through the grandparenting route.

Eligibility and Training

SB 803 dictates that individuals who wish to be certified must meet the following eight eligibility requirements:

- be at least 18 years old
- possess a high school diploma or equivalent degree
- self-identify as having lived-experience
  - with the process of recovery from mental illness
  - with substance use disorder as a consumer of services
  - as a family member, partner, or caregiver of a consumer of these services
- be willing to share their experience
- have a strong dedication to recovery
- agree to adhere to a code of ethics in writing
- successfully complete curriculum and training requirements
- pass a certification exam approved by DHCS.

Individuals also must adhere to a code of ethics and complete recertification requirements every two years.

The certification process is managed through a website developed and maintained by CalMHSA (undated-a). Individuals can register and upload the required documentation from the site, which also provides comprehensive information on certification requirements, application instructions, policies and procedures, training and exam requirements, approved training entities, and associated fees. The website also has a certification registry, a data dashboard that provides real-

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time demographic data on all certified individuals, and mechanisms for addressing grievances and appeals. To apply for initial certification, candidates register online and upload proof of completion of an approved training program, a government-issued identification and a high school diploma or equivalent. As of December 2023, the total fee for initial certification is $250, which comprises a $100 application fee and a $150 exam fee. MPSSs must be recertified every two years by completing 20 hours of continuing education and paying an $80 certification renewal fee. DHCS offered an initial set of scholarships, but scholarship funding has been exhausted (as of early 2024).

Additionally, a grandparenting pathway to certification was available during early implementation of the certification program (through June 30, 2023). Grandparenting requirements for certification consisted of the following:

- being employed in a peer role on January 1, 2022, and at the time of application
- having at least 1,550 hours of paid or unpaid work experience as a peer in the past three years (at least 500 hours must have been completed in the past year)
- completing 20 hours of continuing education (six hours in law and ethics)
- completing a peer training from a list of acceptable vendors
- submitting three letters of recommendation, from a supervisor, a colleague, and a self-recommendation
- successfully passing the state-approved MPSS certification exam.

Training courses are offered by multiple vendors in multiple formats, such as in-person, online, hybrid, and asynchronous (self-paced within a given time frame) options. After being certified, MPSSs are eligible for enhanced training in one of four areas of specialization:

- parent, caregiver, family member peer
- peer services in crisis care
- peer services for unhoused individuals
- peer services for justice-involved individuals.

For example, an additional 40-hour course is required for the first area of specialization (parent, caregiver, family member peer). To defray costs of the required 80-hour training or the specialization training, DHCS offered scholarships of up to $1,600.

The Certification Exam

Once training has been completed, applicants must upload their training certificate in the online application portal and register to take the certification exam. The exam consists of 120 multiple-choice items developed by CalMHSA in consultation with subject-matter experts and a test development company. Applicants can complete the 2.5-hour exam through a live online platform or at an in-person testing center. If the candidate does not pass the exam, they can retake it up to two times within 12 months from the initial application. There is a $150 fee for each attempt.

Need for Preliminary Study to Guide Future Evaluation and Policy

Given that the legislation is now being translated into practice across the state, it is important to understand how it is affecting mental health and substance use treatment and whether stakeholders are noting any emerging implementation challenges. Drawing from prior literature, we focused on four major areas of concern:

- impact of the certification program on the integration of peers into mental health and substance use services
- impact of the certification program on working conditions for peers
- impact of the certification program on service user outcomes
- how the certification program is implemented.

Integration of Peers into the Behavioral Health Workforce

It is important to understand whether and how MPSS certification has had an impact on the integration of PSSs into behavioral health care services in California. By standardizing training around a clearly defined set of competencies, certification might help clarify the roles and responsibilities of peers within the complex treatment teams that are common in community-based behavioral health services. Because peer roles are not always well defined across settings, peer roles are often poorly understood by peers and other staff on clinical care teams. For instance, a common concern is that peers are delegated to clerical tasks that do not draw on their unique knowledge or skills (Gaiser et al., 2021). One qualitative study of PSS certification highlighted varying interactions of certified PSSs with coworkers and supervisors, ranging from "supportive to confused about the peer specialist role" (Siantz, Pelot, and Ostrow, 2023). Prior studies suggest that increased knowledge and awareness of peer roles and responsibilities arising from certification could lead to greater job satisfaction, cohesion, and effectiveness among peers and the wider clinical care team (Kent, 2019; Mutschler et al., 2022).

One issue that recurs in the literature as a challenge is the appropriate supervision for PSSs. The need for supervision is widely recognized as a means to clarify the peer role and deliver peer support services with fidelity (Chinman et al., 2016), but there are different perspectives on the nature of the supervision and who should provide it. One the one hand, supervision by clinical staff is thought to be important because of the need for professional guidance in integrating peer support services with other aspects of the treatment plan. On the other hand, supervision by more-experienced peers is thought to be important because peers have better understanding and more-relevant experiences with the unique roles that peers play (Foglesong et al., 2022). Supervision provided by a more senior individual within one's discipline is not unique to peer support services; it is a common requirement in other clinical disciplines, such as social work (National Association of Social Workers, 2013). In practice, both types of supervision—as well as hybrid models—could be in use for PSSs (Gaiser et al., 2021).

Impact of Certification on Workforce and Career Development

Certification could also affect peers' working conditions and career development. A recognized credential can offer a PSS a stronger position when seeking employment than they would have when depending exclusively on their personal experience and connections. In addition, the ability of employers to receive Medi-Cal reimbursement for PSS services provides a new incentive to employ PSSs, whose services were previously funded through other, less sustainable funding streams in California, such as the Mental Health Services Act (Brasher and Dei Rossi, 2012). A recent longitudinal study of PSSs who became certified in four U.S. states showed high rates of employment among PSSs compared with the general population of adults with a history of psychiatric conditions (a population with relatively high rates of unemployment) (Ostrow et al., 2022). Participants who worked in peer positions reported higher likelihoods of disclosing their psychiatric history, greater job satisfaction, and higher receipt of employment benefits (such as health insurance and paid time off) than participants who were not employed as peers. Another study highlighted varying experiences with securing employment following certification (Siantz, Pelot, and Ostrow, 2023), and, aside from research

by Ostrow and colleagues (2022), there is limited research examining whether statewide certification can improve peers' salary and other employment benefits (such as insurance, vacations, or sick leave).

The potential for career advancement and support from the agencies for whom peers work are important issues for PSSs. In a nationwide survey, peer support workers perceived a broad devaluation of the peer role in society and among coworkers and agency leadership; financial barriers and lack of support for professional development from employers; and internal barriers to continuing education, such as internalized stigma and perceived disability (Jones, Kosyluk, et al., 2020). In that study, 80 percent of PSSs were interested in enrolling in or returning to higher education, but many perceive significant barriers to doing so (Jones, Kosyluk, et al., 2020). Notably, peers who are employed in peer-run organizations tend to report higher levels of support for career advancement and more-positive organizational climates than peers employed in conventional mental health settings (Jones, Teague, et al., 2020). In summary, lack of agency support for higher education and career development might lead to greater turnover and limit the potential of the PSS workforce.

Impact of Certification on Service User Outcomes

Certification is also designed to improve the ability of PSSs to positively affect clinical and social outcomes for service users. In general, peer support services can lead to improved service user outcomes in such areas as mental health symptoms, social engagement, quality of life, and treatment engagement (Gaiser et al., 2021). However, there is little evidence that certification, specifically, leads to improved service user outcomes. A parallel body of research among behavioral health care clinicians has shown that training in evidence-based practices likely results in improved clinical skills, but measuring impact on client outcomes remains a challenge (Frank, Becker-Haimes, and Kendall, 2020). It is reasonable to assume that culturally competent training of peers as part of the certification process would lead to improvement in peers' knowledge and skills to do peer support work. These skills, in turn, could lead to improvements in service user outcomes, including greater satisfaction with treatment and reduction of mental health and substance use disorder symptoms.

Experiences and Implementation of Certification

Finally, this evaluation aimed to identify lessons learned from the implementation of MPSS certification. Ideally, perspectives should be gathered from a diverse group of stakeholders, such as service users, peers, clinical staff, and supervisors. This will help uncover pragmatic issues related to implementation, including barriers or facilitators of different aspects of the program (such as training or experiences taking the exam) that can be addressed. For instance, peers generally report positive certification training experiences (Siantz, Pelot, and Ostrow, 2023), but some peers (such as those with a designated psychiatric disability) might be at greater risk of dropping out of peer specialist training programs (Cunningham et al., 2022), and they could also encounter other logistical barriers, such as difficulty finding transportation. More broadly, organizational culture, training, and role definitions have been identified as key factors affecting implementation of peer support services (Ibrahim et al., 2020). These areas were identified as key issues throughout the literature review and will be explored in this preliminary evaluation of the MPSS certification program.

Goals of This Report

This evaluation was designed to provide insight into early implementation of the MPSS certification program that will inform ongoing improvements and future in-depth evaluations. We conducted qualitative interviews with three groups of stakeholders—administrators of programs that employ PSSs, individuals working as PSSs, and PSS service users. PSSs were in different stages of certification, with some certified through the MPSS program and others or planning to get or in the process of getting certified. We addressed the following three evaluation questions:

1. How has MPSS certification and Medi-Cal reimbursement affected integration of MPSSs into behavioral health care?
2. Is there early evidence of an effect of the MPSS program on service user outcomes?

3. What are the early lessons learned about MPSS integration in care? What would make the program more successful?

We use evidence from our efforts to answer these questions, summarize early lessons learned, and make recommendations to assist with continued program improvement and implementation.

Methods

Sampling and Recruitment

We worked with CalMHSA to select a diverse group of counties from which to recruit informants for qualitative interviews. We chose six counties of varying size in different regions of the state. Priority was given to counties with established peer support services and established relationships with CalMHSA to ensure successful recruitment of individuals with experience of the certification program. This evaluation was based on a convenience sample, with respondents initially recruited through county contacts and then by word of mouth. CalMHSA reached out to individuals working in leadership positions in County Behavioral Health Plans in each selected county. We then met with each contact to discuss the study and our goals, and to ask for help in recruiting interviewees.

We recruited three different types of interviewees: administrative staff, PSSs, and users who receive peer support services. Administrative staff were recruited from agencies identified by our county contacts as employing PSSs. Our goal was to recruit similar sample sizes across the three groups. The agencies we drew from were clinical programs, drop-in centers, and peer-run organizations. PSSs were recruited through direct referral from our county contacts and through word of mouth. Information on how to participate was shared by participants with their colleagues. PSSs were eligible to participate in the evaluation regardless of whether they had completed the certification program. Service users were recruited through our administrator and PSS interviewees. Flyers with information on how to participate were distributed to the participants who shared them with their networks.

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Interview Topics

Our team developed semistructured interview protocols for each type of informant. The interview protocol for administrators discussed implementation of peers into their programs, how peers are integrated into clinical workflows, and any changes or impacts observed since the certification process began. We discussed how many peers they work with in their programs and any impacts of certification they have seen on PSS skills or quality of care, employment conditions or pay, and client outcomes.

The PSS interview protocol asked questions about the process of becoming certified, from studying and taking the exam to any barriers they encountered. We also asked whether and how the certification process changed their job responsibilities or affected integration with the care teams they work on and about any impacts that becoming certified has had on their clients and future job plans. The protocol for service users discussed their history of working with peers and any changes they have observed since the certification process was implemented.

Procedures

All evaluation procedures were approved by the RAND Human Subjects Protection Committee. We

obtained verbal consent for participation and audio recording from the participants. Interviews lasted between 30 and 60 minutes and were conducted using Zoom.gov, which enables secure recording. Five interviews took place over the phone and were not audio recorded. Detailed notes were taken during the interviews, and the audio recordings helped fill in any missing gaps. Respondents received an evaluation participation incentive in the form of a $50 Amazon gift card after completing the interview as compensation for their time. Recordings were uploaded to Kiteworks, a RAND secure site, and the recordings and notes were available only to the evaluation team.

Completed Interviews

Our team conducted 52 semistructured qualitative interviews with the three different groups of individuals, as shown in Table 1. We spoke with 17 administrative staff. Two administrative staff members shared that they were also certified PSSs but that their current role was administrative. We interviewed 22 PSSs and 13 service users. For two of the service users, information on the county in which they live and receive services was unclear.

Data Analysis

We used techniques for rapid qualitative data analysis to summarize findings across each of the three groups of respondents (Vindrola-Padros and Johnson, 2020; Taylor et al., 2018). We created a standard abstraction form based on the issues identified in the literature review. After each interview, the interviewer completed the form by recording the respondent's comments related to each issue. Interviewers could record multiple comments related to each issue for the same respondent. The abstraction forms were compiled by respondent group in an Excel file for analysis. In addition to the abstraction forms, the audio transcripts were transcribed to text using the automated transcription function in Microsoft Word to assist in identifying quotations. Throughout the report, we edited quotes for readability when needed.

For analysis, individual team members initially summarized the responses related to each issue highlighted in the abstraction forms within and across the respondent groups and identified quotations from the interviews to illustrate the major themes. The summaries were then reviewed and discussed by the entire research team, until a consensus was reached regarding the findings. When possible, we identified major consistent themes across groups and identified significant exceptions. If a single consistent theme was not identified, we aimed to describe the variety of responses. All team members participated in identifying additional quotations and writing up the results.

Results

Experience of Our Sample

As noted in the "Methods" section, this evaluation was based on a convenience sample, with individual respondents recruited first through county contacts

TABLE 1
Interviews Completed for California's Peer Support Services Evaluation

County	Administrators	PSS	Service Users	Total
Alameda	4	0	0	4
Humboldt	5	6	1	12
Los Angeles	2	3	2	7
Riverside	6	6	3	15
Other[a]	0	7	7	14
Total	17	22	13	52

[a] Other counties were Kern, Santa Barbara, Stanislaus, Glenn, and Butte.

and then through word of mouth. To provide additional context for interpreting the results, we describe the variety of workplaces, positions, and experiences with PSSs and with the MPSS certification program among each of the three groups of respondents.

Administrative Staff

Our interview team spoke with 17 administrative leaders from Alameda, Humboldt, Los Angeles, and Riverside counties. The administrators supervised anywhere between one and 80 PSSs within their organizations. Most of the organizations where these respondents work employ PSSs with and without Medi-Cal certification. One organization did not have any certified peers, noting that a few have signed up for the certification process but have not completed the certification. Two leaders we spoke with did not work directly with peers; one organization provides training for peers throughout their county. Additionally, two administrators mentioned they had experience as PSSs themselves, providing examples of career advancement into leadership positions. Administrators discussed opportunities for career advancement as a future goal for certified PSSs during interviews. Some of the programs have had peers embedded in their services for decades. One program has been peer run for more than 30 years, another program shared that they have used peer services since 1999, and another has worked with peers for more than 14 years.

Peer Support Specialists

We spoke with 22 PSSs from five counties. Of the PSSs we interviewed, 11 were Medi-Cal certified, with three of those 11 grandfathered into certification. Eight had not been Medi-Cal certified, but three of those eight had either completed or begun the Medi-Cal certification training process. These eight peers might have received certification earlier in their careers, but we did not discuss prior certifications in our interviews. Some of the PSSs we spoke with were recipients of peer support services in their past. Four peers had been in the field for a year or less, eight had been in the field between one and five years, and nine had been working in the field for more than five years, with a few having more than ten years of experience. Only a handful of peers also took additional specialized training following certification, with some noting they did not know that was an option. Peers reported working with a mix of clients—people with mental health conditions, substance use disorders and co-occurring disorders; people experiencing homelessness; and people involved with the justice system. Some peers worked with young people and at least two peers focused on individuals ages 55 and over.

Service Users

Our team interviewed 13 service users from five counties. Most interviewees had been working with their PSSs for at least a year. Some had received peer services for more than ten years, noting the importance of this type of support throughout their lives. Some service users were aware of the certification program; others had not heard of the certification program and did not know whether the training would make a difference in the quality of care they received. The service users described a variety of services and supports they receive from peers, such as rides to the Department of Motor Vehicles or food banks, help filling out paperwork for disability benefits, and emotional support and encouragement. Some users also attended groups run by peers, including an emotional support group and a game night.

Participant Views and Experiences with PSS Services

All three groups of respondents highlighted unique contributions that PSSs make to treatment and recovery. Administrative staff emphasized how PSSs communicate with service users in ways that clinicians cannot. One administrator discussed the potential benefits that PSSs offer to clinicians, providing insights regarding their experiences and enabling the clinicians to be more effective: "[PSSs can] walk with the providers and alert them to potholes and bumps in the road that they may not see coming. This perspective is different from any other mental health staff and is important for the client's experience." Administrators also recognized the positive impact peers can have by providing service users examples of successful recovery: "This idea of hope: 'Oh you're a

According to service users, PSSs made them feel more comfortable about being in treatment or recovery-oriented spaces.

model for what I could be, I could use my life to help other people and get paid for it.'"

PSSs described several practical supports they provide that contribute to service users' well-being and ability to live independently in the community. Examples mentioned in our interviews were giving people rides to food banks, making medical appointments, accompanying people to court appointments for moral support, and helping find housing or other needed services. Critically, PSSs can do this while acting as trusted partners whose relationships are built on shared experiences and perspectives.

Service users also emphasized the positive mentoring aspects of their relationships with PSSs. Service users contrasted PSSs with clinicians in terms of the level of trust in the relationship and the consequent ability of a PSS to motivate them in their daily lives. For instance, one service user described how they were initially skeptical of their PSS but came to appreciate the relationship:

> She [the PSS] would help me with my schedule and, like, making calls for appointments and keeping me accountable. And she would give me rides if I needed to go places. She would take me and be there for emotional support. And then, yeah, she worked very good with my therapist, each played their own role and complemented each other.

This sense that a PSS provided accountability was echoed by another service user who struggled with substance use.

According to service users, PSSs made them feel more comfortable about being in treatment or recovery-oriented spaces. One service user described the positive feeling she had the first time she attended a peer-run program: "I got transferred (into the program) and I had this feeling that I was supposed to be there, it was a very welcoming environment, and I was like, 'I'm happy here.'" For this person, who was also receiving therapy from a psychologist, the PSS provides an important complement: "I feel like, with peer support, it's a little more casual, and it doesn't have to talk about deep stuff most of the time . . . We can just talk like we're friends. I feel like that's what's helpful with the whole relationship. That works very well together with the therapist. I only have an hour to tell my therapist everything." Another service user simply said, "I feel more comfortable talking to her (the PSS) than I do to a clinician."

Impact of Certification on MPSS Skills and Contribution to Care

Respondents Emphasize the Impact of Certification on Understanding of the MPSS Role

Administrative leaders and PSSs themselves described skills that peers had learned as part of their certification training, such as motivational interviewing and de-escalation techniques. One administrator interviewee mentioned improvements in how MPSSs approach advanced clinical problems, such as discussing suicidal crises with service users. However, the more-profound changes associated with certification, according to our respondents, had to do with how MPSSs understood their distinctive role in recovery-oriented services and their ability to effectively fill that role. As one MPSS said, "I was doing a lot of case management before I did the whole peer certification thing, and then, once I went through that, I saw more of what exactly my role is. I'm a peer supporter, and it is my job to advocate for the perspective of the peers and community members that we serve."

Certification Clarified Role Boundaries and Increased Self-Confidence of MPSSs

MPSSs commonly told us that the certification process led to a better understanding of the appropriate

boundaries around their roles as MPSSs relative to other types of staff, such as case managers and therapists. The improved understanding of the role of the MPSS, they reported, helped them to be more effective in providing peer support. A typical statement was: "I am more aware of boundaries of the position. I learned the difference between case management and peer coaching. The training taught me what is my job and what isn't. That's pretty important." Interestingly, the greater appreciation of professional boundaries by MPSSs was welcomed by some of our administrator interviewees, who felt better able to integrate MPSSs into their clinical teams. One program administrator, who was also certified as an MPSS, said that the certification changed their program's operations by providing more structure to the roles: "We now have a template for what they are supposed to do."

Along with a better appreciation for the MPSS role, respondents commented that the certification had led MPSSs to have more confidence in their work. One MPSS said, "It gave me a little bit more confidence in myself within my role to be able to speak out within my scope of practice. So that kind of helped me out, just more in confidence." Another MPSS tied the certification to their self-confidence and their sense of responsibility for the quality of their work:

> It's more of a responsibility. Like, I'm certified. I need to hold up my end of the deal and provide the services that I'm supposed to provide as being certified—that is responsibility. Well, then, that responsibility alone helps me to feel a little bit more confident in providing the services.

The increased confidence was also noted by administrators and service users. An administrator told us that "[w]hile the services have remained constant, the level of feeling like 'I know what I'm doing' from the peers has gone way up . . . they feel a lot more confident." A service user commented on the apparent effect that certification had on a peer with whom they had been working:

> I think it has helped. It has helped her a little bit. I don't notice it, but I have felt this, sort of, more confidence and this sort of better-feeling kind of energy. I think they end up feeling a lot more as one who is prepared or, like, productive and responsible. They seem a lot more equipped, well equipped to handle their job.

Views on Supervision of Peers Were Mixed

Among some of our respondents, supervision of peers was an issue of concern. For some administrators and MPSSs, certification created a welcome opportunity for peers to serve as supervisors of other peers, offering oversight and guidance that only another peer could provide. According to one administrator, having clinicians provide supervision can make the supervision sessions "turn into a therapy session," which, according to this interviewee, is not helpful to the peer. However, in interviews where supervision was discussed, respondents indicated that peers in their programs continue to be supervised by non-peer clinicians. Although there was interest in having peers serve in supervisory roles, most of our respondents reported that there had been no changes in supervision of peers in their organizations that resulted from the introduction of the peer certification program.

Respondents Had Mixed Views of the Impact That Certification Has Had on Clinical Outcomes

Despite consistent suggestions that the MPSS certification process was associated with advancement in the quality and use of peers' clinical skills, interviewees did not report that the certification process was associated with improvements in clinical outcomes among MPSS service users. Some clinic leaders and MPSSs reported that it is likely too early to see any changes in service user outcomes associated with the recent certification of MPSSs. Others suggested that the certification process was unlikely to have a substantial impact on service users' outcomes because relationships between many peers and service users were already of a high quality before certification. Alternatively, advancements in the quality of PSS clinical skills could lead to quality improvements for service users that are hard to measure. For example, some interviewees suggested that service users who view MPSSs as role models adopt more-hopeful attitudes about their own abil-

ity to overcome challenges. One MPSS interviewee reported that the certification process "might be something that would provide hope" as service users observe peers advance in their careers.

Although service users reported that peer support services were helpful, there were mixed responses to the certification program among this group. As we expected, some service users were not aware of the certification program even though they had been consistently receiving peer services. A couple were aware of the certification program because peers that they worked with had become certified and discussed the experience. For instance, one told us about a party that was held at their program for a peer who had passed the certification exam. Some told us that the peers were fine before certification and should not be required to complete any additional training; others suggested that the certification had improved the skills of the peers they work with. One said that the peer he works with was "better equipped to handle their job" after certification. Another said, "I have felt more heard and listened to" when working with their newly certified PSS.

Impact of Certification on Job Responsibilities

When we discussed how certification had affected the job responsibilities of MPSSs, the most common response was that there had been little or no change in the formal requirements of the job. For example, one MPSS who had years of experience prior to becoming certified said that the certification had not changed her job: "It doesn't really make that much difference in my job. Not really. I was doing the same thing before I got certified." Other comments, however, suggested a variety of informal changes that have altered the nature of the work to some extent. This point was suggested by an administrator who said, "They (peer specialists) are acknowledging their role. Their job description has not changed, but their role has been elevated." Another said, "I don't think anything tangible has really changed, quite honestly, but it's just, it feels good to [say], 'You're a certified peer specialist.'"

Although many respondents minimized the changes that had been made to the jobs of peers with certification, some described meaningful changes. These were not consistently reported across respondents, but they are important to note because they indicate a potential trend toward more-formal substantive changes in the job responsibilities of MPSSs.

- **More autonomy in seeing cases:** An administrator shared that "[t]he certification will allow folks to do things they haven't been able to do in the past, like hold cases without clinicians. They bill at a higher rate. Have a taxonomy code that specifies them as a specific provider."
- **Better integration with clinical teams:** Another administrator explained they "make a real big point of [emphasizing] that I want the therapist and the peer [to be] collaborating on cases, and I don't know for sure if that's happening at other sites. We've been doing it that way, but [now with the certification] they're doing it more. I can see them applying it more and connecting the pieces more."
- **Focusing on work appropriate for peers:** A peer stated that "[t]here is a bit more freedom in the role. I can say no to things that are not 'peer productive.'"
- **New requirements for documentation:** An administrator observed that "[t]he certification has resulted in better documentation of the work she does—so that other people can pick up where she left off when she is not around."
- **Certification becoming a job requirement:** One respondent who recently began working as a PSS was required to take the training and become certified within the first six months of employment.

Impact of Certification on Working Conditions and Careers for MPSSs

Some Early Signs of Change in Working Conditions for MPSSs

When administrative staff and MPSSs were asked about the impact of the certification program on working conditions for MPSSs—such as pay, work hours, or benefits—the most common answer was

that there had been no effect. Most MPSSs, including the individual cited earlier who said that certification did not make a difference in her job, indicated that there had not been changes in their formal roles and responsibilities at work after they received their certification. One administrative staff interviewee who works in a program that employs multiple full-time MPSSs who have been certified said that she had asked her supervisors at a staff meeting whether the peers who had been certified would receive a raise. The response was not promising: "I got laughed at."

Although interviewees tended to downplay changes to working conditions for peers that resulted from the certification process, there were several indications that positive changes had occurred and that others are being considered. First, regarding pay, two MPSSs interviewed from the same county reported that they had received wage increases, albeit small ones. An MPSS reported that their county initially was not going to increase pay for certified MPSSs but then decided to do so. However, the increase was only 27 cents per hour. Several interviewees among both MPSSs and administrators noted that their organizations or their counties were having discussions about increasing wages or offering bonuses to PSSs who get certified but had not yet made decisions to do so. The low level of pay for PSSs, even with certification, was commonly noted by both PSSs and administrator interviewees. As one MPSS who had received a raise after getting certified noted, "How can I model recovery when I can barely make ends meet myself?"

There were also indications that additional career options are being opened for MPSSs who have been certified. As one administrator interviewee said, "Certification lends itself to seeing the peer role as a career role." Another administrator interviewee in a large clinical program that employs seven PSSs indicated that her program has expanded opportunities for professional advancement for peers by adding peer supervisory positions that come with higher pay and time dedicated to advanced training and meetings. An administrator in another county told us that they are considering ways that the certification program can be integrated into a workforce development program they are creating. There was some evidence that certification is coming to be considered

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an important hiring criterion, although it is not considered essential. As one administrator interviewer explained,

> I would definitely hire a certified peer before somebody who wasn't certified, but if it's a choice of a poor certified peer versus somebody who doesn't have a certification [but] who really has that 'thing,' whatever it is I'm looking for, I can teach the other stuff and get them into the training, I'll get them through the certification process, so I'll hire the noncertified.

According to several PSS interviewees, certification was required for their position. As described already, one PSS was expected to complete the certification process within the first six months of their employment.

PSSs View Certification as an Important Credential

PSSs themselves tended to see the certification as an important credential to have for their own career advancement, although there were exceptions—

Scholarships and financial support were viewed as very helpful among peers who had been certified.

mainly individuals who had been working as peers for many years prior to certification. MPSSs who valued the certification as a career milestone were divided between those who wanted to continue to develop their unique position as a peer and those who see certification as a step toward further training or a clinical or administrative role that is not a peer position. An example of the former is a PSS who has experience working for a county behavioral health department and a peer-run organization. He has done multiple trainings in topics related to peer support in the past and plans to take the PSS certification training, provided that he can get financial support for taking the test. His motivation for getting the certification, which is not required by his employer, is that he thinks the training will be interesting and the credential will be helpful in getting peer support positions inside or outside the county behavioral health system in the future. Another PSS, who was relatively new to the role, expressed a similar position, saying that they were interested in certification because it would help them improve in their role as a peer: "The certification is really important because I think it would give me the boundaries and the language I need to define my role."

Other PSSs, who were also appreciative of the certification program, saw it as a step toward a career in behavioral health services as someone possessing peer experience but with primary responsibilities as a clinician or administrator. For instance, one MPSS, who had recently been certified, had become a PSS after years of working in restaurants. She now hopes that the certification will help her pursue additional training in social work and, ultimately, a career as a clinician or care manager in behavioral health. Another peer had already received a promotion to a caseworker role after becoming certified and is concurrently enrolled in a master's program with the intention of becoming a licensed clinician. Some interviewees pointed out that there is a tension between these two points of view. One interviewee who works for a peer-run organization was concerned that the certification program would push people away from peer services toward other career paths, a pattern they referred to as "peer drift."

Experience with the Peer Certification Process

Rocky Start to Implementation

Some peers who had completed certification early in the process reported that initially there was confusion around requirements for certification and that things "changed a lot." There were a few reports of problems submitting documentation through the website, but these tended to be fixed rather quickly. A few other peers noted that the certification process took longer than expected, delaying their ideal timeline for obtaining certification. Peers acknowledged that it is to be "expected" that things would not always go smoothly in a new program. For the most part, peers reported that it was easy to contact CalMHSA if questions or problems come up, and they appreciated that CalMHSA was responsive to questions and concerns they had as they went through the certification process:

> [CalMHSA was] pretty easy to communicate with. There was a phone number and website available, and someone got back to me the next day. That was huge. A lot of times in some of these agencies, we don't always get back to people. The fact that someone was so prompt was huge. Everything was centralized.

Lack of Awareness of Specializations

There was a general lack of awareness among peers about the four specializations offered through the MPSS certification program (such as peer services for unhoused). This could be the result of specializations not being available yet for MPSSs who com-

pleted certification early. Although many peers had experience providing services relevant to the specializations, only one peer reported completing the specialization training (in the parent, caregiver, and family member category). Peers tended to identify themselves as "generalists" or with their primary area of focus ("mental health"), or with job titles used by their agency or county.

Difficulty Obtaining Required Documents for Certification

Applying for scholarships and certification required a lot of paperwork. Obtaining high school transcripts was described as especially challenging (for one peer, this was their "biggest challenge"). Obstacles mentioned were requesting diplomas from school districts that have unclear instructions, for peers who completed high school in another state, and for peers who completed high school many years ago. Obtaining copies of diplomas was also difficult for peers whose education was delayed or negatively affected by their lived experience. One peer noted that she had dropped out of high school, and it took her many years to go back and complete her General Education Diploma (GED). As she put it, "sometimes not getting a diploma is a part of the person's journey." Another peer with a self-described learning disability was frustrated by having to provide a doctor's note to document this condition rather than being able to submit her educational records as proof.

Interestingly, one peer noted that those who went through the initial certification almost had a "lower burden" than those who were grandparented in. Grandparenting seemingly had more documentation requirements, which "created a lot of anxiety and chaos countywide," especially involving high school diplomas.

Difficulties obtaining required documentation resulted in delays in certification for some peers. One peer noted that she was waiting to get a digital copy of her high school diploma, which she needed to be able to take the exam. A clinical supervisor noted that, out of seven peers she supervises, certification was being delayed for one peer because they were having difficulty obtaining a copy of their high school diploma. Generally, participants reported that CalMHSA was quick to respond to questions or difficulties. One peer recommended that there be a designated PSS who could assist with enrollment and paperwork.

Concerns About the Cost of Certification

Scholarships and financial support were viewed as very helpful among peers who had been certified. At one facility, supervisors reported that all peers have taken advantage of the scholarship program, and this has resulted in the clinic incurring no costs related to certification. Peers reported that receiving the scholarship made them feel "very grateful"; they also reported feeling that they "did not have to worry about the financial aspects" of certification and "would not have been able to do it without the scholarship." They also appreciated being paid by their employer while attending training. All of these benefits were said to be especially helpful because some peers were described as living on a fixed or limited income.

Peers and clinical staff also had concerns about the limited number and termination of scholarships. Participants expressed concerns about future costs of certification incurred by peers who have not yet been certified, describing this as a "big barrier" to certification for peers in the future. Some participants reported that termination of scholarships had already resulted in certification delays for some peers.

Clinical supervisors mentioned they are looking for ways to cover the cost of the training, following termination of the scholarship program. In Riverside County, certification costs are at least partially covered by the county. Without this support, one peer reported, training costs "would have priced out a lot of people." In other instances, costs have been paid by the agency. However, these costs might be difficult for smaller clinics or agencies in rural counties to absorb, especially if costs must be factored in for peers who need to travel extended distances and stay in hotels to attend trainings.

Given the financial constraints of peers (and increased demand for certified peers), participants felt that costs should be covered by other entities to make certification more accessible. One suggestion was for CalMHSA to reinstate the scholarships.

Another peer suggested setting standards for determining eligibility for the scholarship, given potential funding constraints. Setting criteria, such as working as a peer for a minimum period, might be best because certification "may not be the best fit for everyone," and not everyone will stay in the role for the long term.

Anxiety About the Exam

Many peers expressed test-taking anxiety and had fears about what would happen if they did not pass the exam. The test was described as "stressful," "strict," and "overly scrutinizing." These stressors seemed greater for those taking the online test at home rather than at a testing center. Online home test stressors that were mentioned were Wi-Fi or connectivity issues, strict monitoring while taking the exam, and lack of confidence in one's computer and technological skills. Participants described how these anxieties might stem from peers' lived experience: "The peer has been through so much in their own lives, there might be some self-doubt." One participant described how peers might experience anxiety with the online test format:

> The one drawback was that for those of us that have certain types of challenges, whether it is navigating a testing system, or school, or high stress or oppressive environments, the process of proctoring the test was very anxiety producing . . . It was stressful. A lot of us may be recovering from persistent mental illness and have traumas and oppression. Having to go through that was pretty hard.

These difficulties with the online test modality led most peers to prefer taking the test in person at a testing center, because it was "more standard" and avoided problems with participants' Wi-Fi connections. Despite these difficulties, many peers reported that the test itself was "fairly easy," "wasn't bad at all," and that some "ambiguity" about the certification process was resolved after learning about the experiences of other peers who had completed the exam. This suggests that a lot of the fear and anxiety was tied to anticipation of taking the exam. Getting help from other peers going through the process was also reported as being particularly helpful when preparing for the exam.

Exam Did Not Adequately Reflect the Training and Experience of Some Peers

Some peers noted that the training materials offered by CalMHSA did not adequately prepare them for the exam. Peers wished that "the knowledge base was more clearly laid out" and that more sample test questions were provided. One participant remarked that the CalMHSA practice exam was "not helpful at all" and that they relied instead on a "very quality practice exam" provided by an organization that provided her training. Offering more test preparation also would have been helpful to quell people's fears and anxieties about the exam. For instance, one peer suggested offering "some training from the departments and from CalMHSA. [They] could maybe put together some videos, reviewing some information that people would have to know, especially for those who struggle with testing." Some more-experienced peers reported relying on the knowledge and skills they have learned through their work experience rather than on materials offered as part of the training. One peer noted that his prior employment experience as a peer "was more valuable than anything written down on paper to study."

There were also some exam questions that pertained to aspects of work with which peers had little experience, particularly around adult substance abuse topics. Relatedly, some peers reported other aspects of the work were missing from the exam, especially questions pertaining to peers who work as family advocates or with children and foster youth. Anther critique of the exam was that it was written "in clinical terms [rather] than in peer language." One peer also mentioned the need for more test preparation resources in other languages and suggested offering the exam in Spanish. Another recommendation was to present a better understanding of the test results. This could involve examining performance on specific questions or content areas—generally speaking, "more specifics in terms of where people needed to improve on the test."

Experiences with the Training

Participants reported a variety of experiences with the 80-hour training. Many peers had a positive experience, stating that they "really liked the component of having to go through the training," and saying that it was "so beneficial." One participant reported that she "wished she had gone through it ten years prior when she first started" peer work, and that it was unfortunate that peers who had been grandfathered in were not required to attend the training. Others were not as impressed by their training experience. One participant remarked that it "was engaging" but that they did not "learn anything new." Another said that it was a "waste of time" and "boring."

These divergent experiences might be the result of variations among the training programs. CalMHSA approved all the trainings focused on coverage of core competencies, but there were variations in format, teachers, and supplemental content. Many participants reported that they thought the content and quality of the training varied widely across vendors. One peer who had not yet been through the training wondered how the training could be consistent, given the wide variety of options offered for completing the training. Another peer who reportedly attended multiple trainings thought that "CalMHSA certified too many agencies to provide the training," and there was a "huge difference in the quality of the trainings." One clinical supervisor observed that some trainings tended to emphasize content about the history of peer coaching over other aspects (core competencies)—which was reported to be less helpful in preparing people for the exam. Trainings that were well regarded tended to provide helpful tools and resources (online recovery groups, training resources to help prepare for the exam); lackluster training experiences tended to be described as brief and lacking in support.

Some described the training as challenging because it required participants to relive, describe, and process their difficult lived experiences. One participant who was very familiar with the standardized trainings offered at one county described the training as "heavy" and "exhausting, mentally and emotionally," while another who had learned about the training only from others described it as arduous as a "boot camp." This particular training was described as difficult because it required a lot of sharing—a challenge for peers who had not adequately processed their prior lived experiences:

> For those who are not quite in recovery or haven't quite directly processed that part of their lived experience, it tends to be a bit more emotional. For those of us who went to therapy, it will still affect me but maybe not as intensely.

This type of processing was thought to be a necessary part of the training so that participants would "have conversations about how you can use that emotional response to work with consumers," and that there are other aspects of the training that are more supportive ("a whole chapter on self-care").

Some peers had specific recommendations for improving the training experience, such as having peer-run organizations offer the trainings. Compared with more-clinical training programs that come from a "medical model . . . the quality is like night and day." Another participant suggested ongoing, self-paced virtual trainings, perhaps on the CalMHSA website. Another improvement could be to ensure that trainings are "more practical and hands on . . . and more relevant to the actual situations that peers encounter."

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Changes reported by our respondents that were the result of the new certification program tended to be incremental rather than dramatic, perhaps because many of our respondents have worked with or as PSSs for many years.

Recertification

The certification program is new, so no peers could speak directly to the recertification process in our interviews. However, a few peers brought up cost concerns when asked if they planned to recertify when the time came. "Many people are not always in the position for recertification cost." Another peer discussed how helpful the scholarship was for initial certification and shared that they did not believe scholarships would be available when it was time to recertify. One administrator explained that the required trainings will help bolster their skills for the recertification process. Training is to "help them for their recertification process and growing their existing skills or to develop skills to help them enter the workforce." Most peers we interviewed asserted that they plan on maintaining their certification status over time and plan to recertify when necessary.

Discussion

In this report, we provide evidence of the early impact of the peer certification program in California based on interviews with more than 50 administrators, PSSs, and peer support service users. Strengths of this evaluation are a large and diverse sample of program participants from counties of different sizes and different regions of the state. The findings were generally consistent across interviews and types of respondents, though we have highlighted areas where there is a variety of perspectives. In this final section, we describe how the findings address the main evaluation questions concerning the impact of peer certification on integration of peers into behavioral health care and service user outcomes, discuss study limitations, and present recommendations based on our findings for consideration by CalMHSA.

Impact of Certification on Integration of Peers and Service User Outcomes

Changes reported by our respondents that were the result of the new certification program tended to be incremental rather than dramatic, perhaps because many of our respondents have worked with or as PSSs for many years. However, some evidence from our interviews suggests that the certification program is already affecting how peers are integrated into behavioral health care and that these impacts are notable. Administrators and MPSSs themselves told similar stories about the impact of the certification program on skills, emphasizing changes in peers' understanding of the distinctive nature of their work, improvements in their ability to establish effective boundaries related to their role as an MPSS, and increases in confidence on the job. Similar views were expressed by some of the service users we interviewed, which is notable because the service users had less direct experience with or knowledge of the new peer certification program. These changes in skills appear to be having broader impacts on how peers are integrated into teams, although most of the changes we heard about were not formal in nature or consistent across programs. Examples of changes in integration of peers are being given a caseload of service users, not requiring sign-off on notes by a clinician and working more collaboratively with a clinical team.

The reports of improvement among both peers and administrators in understanding the roles that peers play is significant given the common finding in prior research that poor role definition is a major barrier to inclusion of peers in mental health services (Hamilton et al., 2015; Manning and Suire, 1996). Improved training and clear job definitions were identified as facilitators of inclusion of peers as staff in a review of qualitative studies (Walker and Bryant, 2013). The contribution of certification to clarification of norms and expectations regarding the skills and roles of peers serving as PSSs might also offer opportunities for integration of peers into more-specialized care roles than they are currently filling or into clinical settings in which they are not yet commonly used. For instance, there is literature describing successful integration of peers into intensive case management teams, inpatient units, and criminal justice settings (Portillo, Goldberg, and Taxman, 2017; Smith et al., 2017; Chinman et al., 2015).

The changes associated with certification are not without challenges or controversy. First, the low pay for MPSSs remains a concern, and MPSSs described fulfilling duties (such as accompanying service users to court appointments) that would be time-intensive and costly if carried out by clinical staff with advanced degrees. There were a few reports from one county that MPSSs were receiving higher pay after becoming certified, but the increases were small. We heard of other efforts to build more-robust career pathways for peers in our interviews with administrators, but the extent to which these are being implemented broadly is unclear. The U.S. Department of Veterans Affairs provides an interesting example in this regard: It employs about 1,400 PSSs across the system in positions paying from $15/hour (GS5) to more than $30/hour (GS10). The development of new career pathways for a PSS is an important positive development, given the historically low pay and limited advancement opportunity for peers (Jones, Kosyluk, et al., 2020; Ostrow et al., 2022), but it remains unclear from this study how significant the improvements will be over time.

Secondly, there is a concern among some that certification encourages peers to take on more-clinical roles, detracting from their distinctive roles and responsibilities as peers. These two issues are interrelated. Despite peers' positive regard for their unique role, the lack of opportunity to earn higher wages could contribute to some certified MPSSs leaving these positions to take on higher-paying roles as social workers, care managers, community health workers, counselors, or administrators. Although the pathway from certified peer to these other positions might be a desirable outcome, its potential impact on the workforce remaining in peer positions is notable. The issue of supervision is a special case of this general issue. Recognizing the need to balance clinical skills and peer specialization in the supervision process, DHCS specified standards for training for MPSS supervisors based on recommendations from the Substance Abuse and Mental Health Services Administration, and CalMHSA developed a training that meets those standards and is offered for free, with financial support from DHCS. In addition to the training, MPSS supervisors must be either a certified MPSS with at least two years of work experience in the behavioral health system, a mental health professional with at least two years of work experience, or a high school graduate with at least four years of experience. The way in which supervision of peers is implemented is likely to vary across counties and programs.

Our respondents were clear that it was too early to observe improvements in the impact of peers on service user outcomes, given the strong therapeutic relationships between PSSs and service users that existed prior to certification. Service users highlighted the value of working with peers and the invaluable impact on their well-being and their recovery. Peers serve as an essential part of service users' care teams and offer a unique relationship that service users said they could not live without. This finding echoes prior studies that have also found service users to have positive perceptions of peer support workers (McCarthy et al., 2019; Hamilton et al., 2015). However, the clarification of roles, responsibilities, and boundaries; increased confidence; and hope that certification can reduce burnout, increase autonomy, and open up career pathways could likely have positive effects on service users (Gaiser et al., 2021; Frank, Becker-Haimes, and Kendall, 2020). These positive outcomes might translate to greater engagement and continuity of care among service users. This was illustrated by the unique benefits

of peers that were commonly reported by service users, in conjunction with other behavioral health services received by non-peer clinicians. We note that there is a general lack of research in this area, and further evaluation of the benefits of MPSS certification on service user outcomes is needed in California and nationwide.

Limitations

Our findings should be interpreted in light of several limitations of the study. First, the sample was selected from a small number of programs within a group of counties selected for their peer support programs. As a result, the sample likely reflects a much higher level of engagement with peer support services than is generally the case across county specialty behavioral health services in the state. We also note the small number of interviewees from Los Angeles County, the most populous county in the state. Unfortunately, interviews with stakeholders from Los Angeles County were delayed until the end of the study, and there was not enough time to do more recruitment. Conditions in counties not included in the study likely differ and might reflect less robust peer support services. Second, descriptions of peer support programs in our interviews were not independently verified. The results are valuable as indicators of how certification is being received, but they cannot provide an overall assessment of its impact. Third, we know from studies in other states that there is a high rate of turnover among PSSs, with many working in other fields or in non-peer positions; this means that the views of the PSSs we spoke with, who were all currently employed as PSSs, might not reflect the full range of opinions.

Recommendations

We offer the following recommendations, based on the findings we have presented, to enhance the MPSS certification program and monitor its functioning and impact over time.

Work with program directors and MPSSs to develop best-practice guidelines for involving peers in a variety of clinical teams. Our interviewees conveyed a sense that certification had enabled innovation in how services are organized that they were just beginning to explore. Sharing lessons learned through this process among practitioners could enable development of best practices and models of care. A learning collaborative model in which practitioners share their experiences implementing changes in the roles of peers could be beneficial. Lessons learned in the counties that are more advanced in the use of peers, such as those in this study, could also help counties that are beginning to develop services with certified peer specialists.

Examine the certification training and examination process for opportunities to remove barriers and improve quality. We did not conduct a detailed assessment of the certification process, but comments from MPSSs who have experience with it offer some suggestions to consider for improvement. To the extent that these suggestions can be accommodated (given other regulatory requirements), they should be considered and barriers to certification should be monitored on an ongoing basis. The two most commonly cited barriers were the financial cost and the documentation requirements. Efforts to encourage employers to compensate peers for their time during the training will also likely reduce barriers to certification. Financial support for advanced training to support MPSS supervisors should also be provided to build more-advanced skills in the workforce. We also note that DHCS has offered scholarships to defray training and exam costs. DHCS has minimized the paperwork burden by requiring only an identification and a high school diploma (or equivalent), but several of our respondents reported difficulty obtaining copies of their high school diplomas. There was also concern among some who had been certified that the exam did not reflect the content of the training and that the content and quality of training curricula were not uniform across vendors. The evaluation team has not made an independent assessment of these issues, but we report these findings in the interest of representing the views of our respondents. An ongoing evaluation of the training and examination process using an evaluation team that includes peer perspectives could help identify opportunities for improvement in the future.

Monitor the certified peer workforce over time. The state should develop methods for monitoring the

California is positioned to be a national leader in addressing these knowledge gaps, which could inform policies and practices to further support the MPSS workforce and improve behavioral health in the state.

certified peer workforce at the county level, tracking the number of individuals being certified, the number working as MPSSs (or not), the positions in which they work, and the pay and employment benefits that they receive. Surveys, such as the ones being conducted by CalMHSA, could be used to monitor reasons for leaving employment as a peer, job satisfaction and burnout, and overall well-being. Although California was late to pass state certification standards into law, there are opportunities to be a national leader in program and policy evaluation that can address and the needs of the PSS workforce.

Examine the impact of certified peers on continuity of care, treatment engagement, and use of acute behavioral health care. To inform overall evaluation of the MPSS certification program, the state could use claims data to examine the impact of certified peers on service user outcomes. With the new Medi-Cal billing codes, recipients of MPSS services can now be consistently identified in claims, providing a valuable resource for future studies of the impact of MPSS services. Controlled studies, with comparisons drawn across time or between counties, could be valuable strategies for using observational data to investigate these effects. Our interviews suggest that the outcomes most likely to be directly affected are related to engagement with behavioral health services. In turn, greater engagement with care could have positive impacts on continuity of care and lower use of acute care, such as emergency department visits or inpatient hospitalizations.

Conclusion

Through SB 803, DHCS has created a way for people with lived experience to have careers in which their expertise can contribute to supporting mental health and substance use service users. In this report, we outlined several positive outcomes that occurred during the first year of the program. Although PSSs were already well integrated into the behavioral health care workforce in some counties, some participants reported greater integration into clinical care teams. MPSS interviewees reported that certification resulted in a better understanding of the unique role and responsibility of peers, added legitimacy, and increased their confidence in performing the role. However, despite hope that certification could lead to increased demand for PSSs and more career opportunities, participants reported few tangible improvements in benefits and wages. There were also lessons learned about the certification process. Participants valued support received from scholarships, CalMHSA program administrators, and other peers, but participants also reported concerns about future costs of certification, difficulty obtaining required documentation, exam preparation and proctoring, and lack of training standards across vendors. Further evaluation is needed to determine whether certification leads to improved working conditions for peers and service user outcomes. California is positioned to be a national leader in addressing these knowledge gaps, which could inform policies and practices to further support the MPSS workforce and improve behavioral health in the state.

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About This Report

In September 2020, California enacted the Peer Support Specialist Certification Program Act (California Senate Bill 803), which established a framework for Medi-Cal Peer Support Specialist (MPSS) training and certification to work in the state's specialty behavioral health systems. The certification program is still in its early stages of implementation, with the first MPSS certifications issued in September 2022. As of January 9, 2024, there were 2,569 peer support specialists who had completed the certification process (California Mental Health Services Authority [CalMHSA], undated-b). To inform continual improvement of the program and help design future comprehensive evaluations, CalMHSA requested that RAND conduct an evaluation of the early implementation of the program.

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CalMHSA

CalMHSA is an organization of county governments working to improve mental health outcomes for individuals, families, and communities. Prevention and early intervention programs implemented by CalMHSA are funded by counties through the voter-approved Mental Health Services Act (Prop. 63). Prop. 63 provides the funding and framework needed to expand mental health services to previously underserved populations and all of California's diverse communities.

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