The Foundation of Peer Support: Where It Started, Why It Works, and the Path Forward

November 2, 2026

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Support by:

THE SOCIAL CHANGERY

CalHHS

Today's Agenda

1. Welcome & Introductions
2. How CalHHS Supports Peer Services
3. The Foundation of Peers
4. The Value of Peers on Interdisciplinary Teams
5. Best Practices & Recommendations
6. Q&A / Discussion
7. Closing & Next Steps

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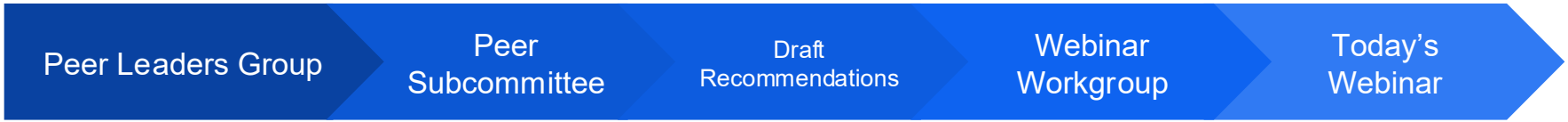


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How Did We Get Here?



Recommendation A.1: Host an educational webinar on the peer role.

Recommendation A.5: Clearly define how peer services are delivered within evidence-based practices, and advocate for peer-specific practices in future list updates.

What Exists at the State

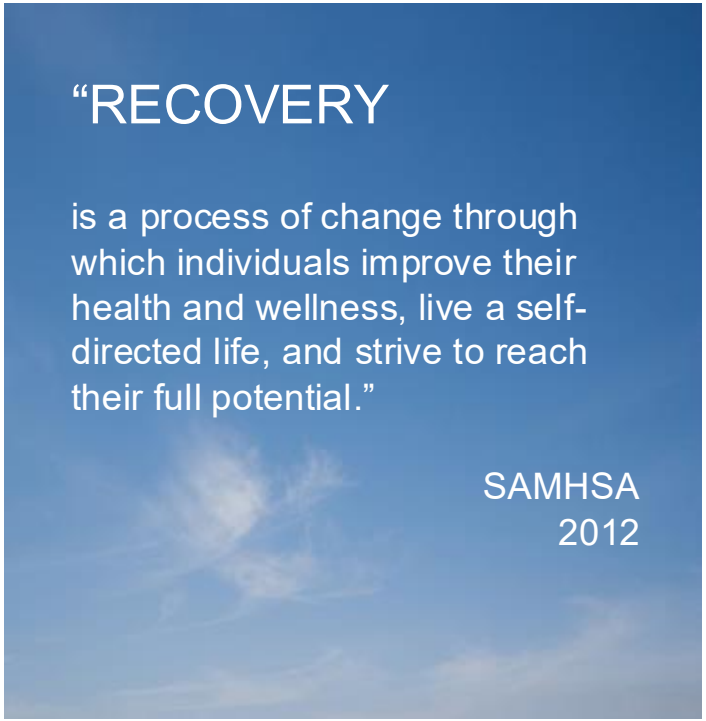
- In July 2022, The Department of Health Care Services (DHCS) launched the Medi-Cal Peer Support Services benefit.
- **Certified Medi-Cal Peer Support Specialists provide recovery-oriented, culturally appropriate services that promote engagement, socialization, self-sufficiency, self-advocacy, natural supports and are trauma aware.**
- Following federal approval, DHCS added Medi-Cal Peer Support Specialists (Peers) as **a unique provider type within specific reimbursable services**. Counties can voluntarily opt-in to provide this valuable resource in one or both delivery systems (Specialty Mental Health System (SMHS), and Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS).
- As of September 2025, **53 counties** include Medi-Cal Peer Support Services as a benefit in one or both of their delivery systems.
- Senate Bill 803 (SB 803), authored by California State Senator Jim Beall sets a standard of seventeen Core Competencies that every Peer Support Specialist is required to know to be certified as a practitioner in California.

DHCS Peer Support Specialist FAQs

Not all Peer Roles are Certified Medi-Cal Peer Support Specialists

- The Medi-Cal Peer Support Specialist certification is only a specific certification requirement for the Medi-Cal behavioral health delivery system to be reimbursed by Medi-Cal for the provision of covered Medi-Cal Peer Support Services to Medi-Cal members.
- Many non-Medi-Cal certified organizations, including peer-ran organizations staff Peer specialists, but funding sustainability structures differ as they do not receive Medi-Cal reimbursements.
- BHIN 20-056 identifies the range of funding sources for peer support specialists that are available outside of the Medi-Cal program.

Foundations of Peer Support



Origin and Values

- Advocacy – psychiatric survivor/consumer movement
- Self-Help/Mutual Aid – relationships, support, recovery

Recovery…

- emerges from hope
- is person driven
- occurs via many pathways
- is holistic
- is supported by peers and allies
- is supported through relationships and social networks
- is culturally based and influenced
- is supported by addressing trauma
- involves individual, family, and community strengths/responsibility
- is based on respect

The Peer Role…

- A peer role is a stand-alone role, just like a case manager role is a stand-alone role
- Peers focus on the development of a relationship first and foremost
- Peers approach the relationship as equals
- The relationship is about mutuality–it is mutually beneficial
- Peers use their lived experience in their roles and model recovery
- How that lived experience is shared to support the relationship is a key skill of the peer role. The peer and the person being supported are equals

A Peer Specialist

Is/Does

- A person in recovery
- Share lived experience
- A role model
- See the person in the context of the person's roles, family, and community
- Motivate through hope and inspiration
- Support many pathways to recovery

Is Not/Does Not

- A clinician
- Give professional advice
- An expert or authority figure
- Approach the person as a case or diagnosis
- Motivate through fear of negative consequences
- Prescribe one specific pathway to recovery

A Peer Specialist

Is/Does

- Function as an advocate for the person in recovery, both within and outside of the program
- Teach the person how to accomplish daily tasks
- Teach the person how to acquire needed resources, including money
- Help the person find basic necessities
- Use language based on common experiences
- Help the person find professional services from lawyers, doctors, psychologists, and financial advisers
- Share knowledge of local resources
- Encourage, support, and praise
- Help to set personal goals
- Serve as a role model for positive recovery behaviors
- Provide peer support services

Is Not/Does Not

- Carry out tasks for the person
- Give resources and money to the person
- Provide basic necessities, such as a place to live
- Use clinical language
- Provide professional services
- Provide case management services
- Diagnose, assess, or treat
- Mandate tasks and behaviors
- Tell the person how to lead his or her life in recovery

A Peer Specialist — SAMHSA's Core Competencies

Category I: Engages peers in collaborative and caring relationships

Category II: Provides support

Category III: Shares lived experiences of recovery

Category IV: Personalizes peer support

Category V: Supports recovery planning

Category VI: Links to resources, services, and supports

Category VII: Provides information about skills related to health, wellness, and recovery

Category VIII: Helps peers to manage crises

Category IX: Values communication

Category X: Supports collaboration and teamwork



Misconceptions



- Lived experience v. Peer Support Specialist - Systems are integrating people with lived experience but struggle to integrate the expertise of Peer Services
- Peer v. peer – providers and systems use Peer (a trained, supervised Peer Specialist) and peer (a person receiving services) interchangeably

Challenges of Supervision

- Supervisors may lack experience and working knowledge of peer practice
- Supervisor may have a clinical approach to service provision
- Many supervision approaches do not incorporate recovery values
- Lack of knowledge among non-peer staff about peer roles and practice
- Organizations may not be aligned with recovery-oriented values, practices, and culture

Peer Supervision – Best Practices

- Recognition of the impact of traumatic histories on all staff, including peer workers, supervisors and the people being served
- Collaborative supervision such as the Developmental Model of Supervision
- Tracking data using a “Kaizen” approach of continuous improvement based on data
- Continuous training and management actions that reinforce the importance of Peer Services for the best outcomes for the people being served
- Rewarding all staff including peer workers for success and celebrating failure as a path to learning
- Incorporating Peer Services into treatment plans, programs, interventions and other agency activities
- Encouraging staff including peer workers to join self-help support groups and/or a peer worker support group to have a place to share issues at work
- Conducting regularly scheduled supervisory meetings
- Incorporate the tools we expect Peers to use in their work into the supervision process.
- Ensuring supervisors of peer workers:
  1. have prior experience/knowledge of peer support work
  2. are willing to supervise
  3. are knowledgeable about supervision concepts and practices
  4. Receive ongoing supervision
  5. Understand the difference between supervision and clinical support
- Supervisors of certified Medi-Cal peer support specialists must meet certain requirements and complete a DHCS-approved peer support supervisory training curriculum.

Evidence

"Peer support is valuable not only for the person receiving services, but also for the behavioral health professionals and the systems in which they work.

Peer workers play vital roles in moving behavioral health professionals and systems towards recovery orientation."

SAMHSA

Peer Specialists:

- Reduce the use of inpatient services (Chinman et al 2014)
- Decrease costs to the mental health system (Trachtenberg et al. 2013)
- Increase social functioning (Walker & Bryant, 2013)
- Decrease hospitalization (Davidson et al. 2012)
- Increase empowerment and hope (Chinman, et al. 2013)
- Decrease self-stigma (Corrigan, et al. 2012)
- Increase community engagement (Min, et al. 2007)
- Increase quality of life and satisfaction (Bologna & Pulice, 2010)
- Increase engagement and activation in treatment (Druss, et al. 2010)

Best Practices and Recommendations

We Use the Words — But Do We Practice Them?

Peer systems use words like mutuality, hope, strengths, choice, and self-determination. Those words lose meaning when services still center hierarchy, compliance, and professional control.

01 Mutuality

Not "expert over patient." Both bring shared knowledge and humanity into the relationship without control or direction.

02 Hope

Lived demonstration that recovery, change, connection, and a meaningful life are possible.

03 Strengths

Starts with abilities, relationships, survival skills, interests, culture, goals, and resilience, rather than only symptoms, deficits, diagnoses, or risk.

04 Choice

Supports informed decisions about one's own life, including options professionals might not choose.

05 Self-Determination

The individual is the primary decision-maker. Services must expand personal agency, not replace it.

06 Connection / Belonging

Reduces isolation through authentic human connection and community — beyond mere service utilization.

Peer values are not slogans — they should change how power, decisions, relationships, and services actually operate.

Peer Support Is More Than One "Practice"

01

Peer support as a profession/service

A trained workforce using lived experience intentionally to support recovery, agency, connection, and self-determination.

02

Core peer principles

Mutuality • Hope • Strengths • Choice • Autonomy • Self-determination • Connection

03

Peer-specific practices & models

WRAP • Intentional Peer Support • Peer Bridging/Navigation • PADs • Purposeful Disclosure • Youth Peer Support

04

Organizational practices

Peer supervision • Role clarity • Team integration • Leadership inclusion • Protection from role drift

Peer support is a workforce, a philosophy, a set of practices, and an organizational approach — not a single clinical intervention.

How Peers Play a Unique Role in Service Delivery

Traditional Clinical Framework

- Diagnosis
- Clinical intervention
- Professional delivers treatment
- Symptom reduction
- Treatment adherence/compliance
- Standardized clinical outcomes

Peer Practice Framework

- Relationship
- Mutuality
- Hope
- Agency and self-determination
- Connection and belonging
- Recovery and quality of life

- Peer services should be evaluated — but against outcomes they are actually designed to produce.
- Evidence standards should not unintentionally transform peer services into clinical services.
- Recognition affects funding, reimbursement, contracting, legitimacy, and scale.

Peer support can further strengthen California’s behavioral health system.

BHSA's Evidence Based Practice (EBP) Biennial List

DHCS developed a list of Early Intervention Evidence-Based Practices (EBPs) and Community-Defined Evidence Practices (CDEPs), including but not limited to:

- Assertive Community Treatment (ACT)
- Forensic Assertive Community Treatment (FACT)
- Wellness Recovery Action Plan (WRAP)

All which include Peer-Support Specialist as valuable components of their models. Full List Here.

- EBPs and CDEPs included on the biennial list address mental health, substance use, and co-occurring disorders and at least one aspect of the required BHSA Early Intervention program components: outreach, access and linkage to care, and mental health and substance use disorder treatment services and supports.
- BHSA will eventually require that all county Full-Service Partnerships (FSP's) must make ACT and FACT services available with the exception that small counties with a population of less than 200,000 can request an exemption.
- DHCS will update the biennial list of EBPs and CDEPs every two years following the July 1, 2026 effective date for the inaugural biennial list of EBPs and CDEPs. The next update to the biennial list will be effective on July 1, 2028.

What Do Peer-Specific Practices Look Like?

1. **WRAP – Wellness Recovery Action Plan**
   Structured, self-directed wellness and crisis planning centered on personal lived knowledge.

2. **Intentional Peer Support**
   A relationship practice built on mutuality, connection, worldview, and moving toward together.

3. **Peer Bridging & Navigation**
   Supporting transitions, benefits, resources, navigation, and engagement through lived-experience expertise.

4. **Psychiatric Advance Directives (PADs)**
   Supporting treatment preferences, values, supporters, and crisis planning before a crisis to strengthen autonomy.

5. **Purposeful Disclosure & Peer Listening**
   Intentional, voluntary use of lived experience to build connection, reduce shame, normalize recovery, and support agency.

6. **Youth Peer Support**
   Developmentally tailored support for youth centering voice, identity, choice, and connection.

Examples — not an exhaustive list.

What Makes Peer Practice Work?

01

Peer-specific supervision

Supervisors understand peer ethics, values, scope, boundaries, and intentional use of lived experience.

02

Clear role definition

Peers are distinct practitioners—not low-cost case managers, substitute clinicians, or catch-all staff.

03

Real interdisciplinary integration

Peers shape program design, team discussions, implementation, quality improvement, and leadership.

04

Choice around disclosure

Sharing lived experience must be intentional and voluntary, never a condition of employment.

05

Respect for lived expertise

Lived experience + training + reflection + boundaries = professional expertise.

06

Organizational culture

Organizations examine power, hierarchy, risk tolerance, decision-making, and treatment of peer expertise.

Successful peer integration requires organizational change — not simply adding a peer position.

Authentic Integration of Peers in Your System

Requires:

- Distinct peer role and scope
- Recovery-oriented peer practice
- Shared power and reciprocal relationship
- Peer-informed supervision
- Disclosure intentional and voluntary
- Lived experience respected as expertise
- Peers included in design and leadership
- Organization examines and changes culture
- Sustainable financing and integration
- Recovery, agency, connection, engagement, and quality of life are also measured

Outcomes of a well-integrated peer:

- Reduce the use of inpatient services (Chinman et al 2014)
- Decrease costs to the mental health system (Trachtenberg et al. 2013)
- Increase social functioning (Walker & Bryant, 2013)
- Decrease hospitalization (Davidson et al. 2012)
- Increase empowerment and hope (Chinman, et al. 2013)
- Decrease self-stigma (Corrigan, et al. 2012)
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Peer integration is not a staffing decision. It is an organizational practice. It must be done right.

It Must Be Done Right.

What poor integration looks like:

- Peer = lower-cost case manager
- Quasi-clinical assignments
- “Mutuality” in language, hierarchy in practice
- No peer-specific supervision
- Disclosure expected
- Lived experience tokenized
- Peers excluded from decisions
- One peer placed in unchanged culture
- Short-term “add-on” funding
- Success measured only clinically

Poor integration results in lost value and missed opportunities for positive outcomes.

Peer Support Works. The System Still Struggles to Use It Well.

01 **Peer support** has an established evidence base and is already used across behavioral health systems.

02 **Yet peers** are still frequently misunderstood, underutilized, or placed into roles that dilute the peer model.

03 **Peer-specific practices** are not consistently recognized in evidence-based practice frameworks.

04 **Funding and reimbursement** structures can unintentionally push peer services toward traditional clinical models.

05 **The next challenge** is not proving that peers have value — it is implementing peer practice with fidelity.

This is a recognition and implementation problem, not an evidence problem.

Moving From Recognition to Implementation

State leadership / CalHHS / DHCS

- Recognize peer practices in EBP & community frameworks.
- Develop peer-appropriate evaluation standards.
- Include peer leaders in defining evidence & quality.
- Protect peer practice from clinical absorption.

Counties

- Contract with peer-run and peer-led organizations.
- Require peer supervision & role clarity.
- Include peers in design, implementation, evaluation, & leadership.
- Review workflows to prevent role drift.

Managed Care & Commercial Health Plans

- Build sustainable reimbursement & contracting pathways.
- Include peer orgs early in network design.
- Fund peer services beyond short pilots.
- Measure engagement, trust, recovery, navigation, & connection.

Provider Organizations

- Define peer roles before hiring.
- Protect peer scope & voluntary disclosure.
- Train staff on working with peers.
- Measure recovery, engagement, agency, connection, & quality of life.

Use the 2028 BHSA evidence-based and community-defined practices update as a concrete opportunity to formally recognize peer-specific practices.

Questions?

Please Join Us for Webinar 2



Register Here

Resources

- Substance Abuse and Mental Health Services Administration (SAMHSA), Supervision of Peer Workers Guidance
- National Association of Peer Supporters, National Practice Guidelines for Peer Specialists and Supervisors
- DHCS Medi-Cal Peer Support Specialists Supervisor Requirements, BHIN 25-010
- CalMHSA, Medi-Cal Peer Support Specialist Supervisor Training
- DHCS Behavioral Health Services Act Biennial Early Intervention Evidence-Based Practices and Community-Defined Evidence Practices List
- Medi-cal Peer Support Services
- Peer Support Services Funding
- National Model Standards for Peer Support Certification

Thank You!

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