Honoring Innovations Report

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Family-to-Family Peer Support: How Can Tribal Communities Join the Growing Movement?

At a recent gathering of tribal system of care grantees in National Harbor, Maryland, participants were asked to raise their hands if they were currently implementing formal family-to-family peer support service delivery. Not one attendee raised a hand. Next, the facilitator asked which grantees *wanted* to implement such formal peer support services. This time, dozens of hands went up.

Family-to-family support is growing rapidly within systems of care. Yet, Indian Country has yet to significantly join this growing movement. The reasons for this are complex. This special double issue of *Honoring Innovations Report* explores how successful family-to-family support service provision is taking shape across the country, discusses the increasing emphasis on certification of peer support providers, and addresses why children's mental health in tribal communities presents unique challenges and considerations beyond those already required by this evolving area of service provision.

Additional Resources

Training, Personnel Practices, Supervision Models
Working Well Together Technical Assistance Center
   www.workingwelltogether.org

National Federation of Families for Children's Mental Health. (2011). *Best personnel practices in parent support provider programs.* Rockville, MD: NFFCMH.

National Wraparound Initiative
   http://nwi.pdx.edu/

Certification
Kaufman, L., Brooks, W., Steinley-Bumgarner, M., & Stevens-Manser, S. (2012). *Peer specialist training and certification programs: A national overview.* Austin, TX: University of Texas at Austin Center for Social Work Research. Retrieved at www.dbsalliance.org/pdfs/training/Peer-Specialist-Training-and-Certification-Programs-A-National-Overview%20UT%202013.pdf

NFFCMH Parent Support Provider Certification
   www.ffcmh.org/certification

Funding
Center for Health Care Strategies, Inc [CHCS]. (2012, May). *Medicaid financing for family and youth peer support: A scan of state programs.* Hamilton, NJ: Centers for Health Care Strategies. Retrieved at http://www.chcs.org/media/Family-Youth-Peer-Support-Matrix-reformatted-070714.pdf

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Background and Definitions

Family-to-family support (F2F), as delivered by peer support providers (PSPs),[1] has been around for decades. However, Obrochta et al. (2011) note that a growing commitment to providing dynamic family-driven care has caused F2F support to expand and evolve in recent years, including "greater specification of program models (including staff qualification requirements for providers and intervention strategies), development of training resources (including core competencies and certification guidelines), and efforts toward establishing F2F support as a billable service" (p. 1).

Many involved within children's mental health would agree that there is a serious shortage of trained workers to provide badly needed services. It is not surprising, then, that systems of care have begun to develop ways to address this need by embedding PSPs within their systems. This "lived experience workforce" (Harris, King, Purdy, & Wells, 2014a) can be comprised of parents, caregivers, family members, and youth who have been service recipients in the children's mental health system.[2]

Parent support providers are currently defined as "primary caregivers who have the 'lived experience' of being actively involved in raising a child who experiences emotional, developmental, behavioral, substance use, or

[1]Obrochta et al. (2011) explain, "The term family-to-family is used to describe the *type* of support offered. The term parent support provider is used to describe the *person* serving as a peer mentor. PSP is a broad term that can be used to describe parents, grandparents, or other family members who serve in the role of parenting a child or youth who has received mental health services." [emphasis added]

[2] While youth can be included in the definition of "peer support providers," youth PSP programs are quite small in number relative to PSP programs that recruit, hire, and train adult caregivers. Because far more has been developed and published on the latter, that is the focus of this article, unless otherwise noted.

mental health challenges. PSPs have experience navigating child-serving systems to access services and supports. PSPs have received specialized training to assist and empower other families who are raising children with similar experiences" (Spencer, Gargan, & Pearson, 2014a, p. 1).

What Do PSPs Actually Do?

Broadly, PSPs do the following:

- "Share lessons they have learned from experiences gained from identifying and accessing services, applying crisis prevention techniques, and wellness management skills" (National Federation of Families for Children's Mental Health [NFFCMH], 2012, p. 1)
- Model successful behaviors (see the "Ready" column in Table 4 for examples)
- Provide parents the kind of support that allows them to maintain hope and pursue formal services and other support
- Reflect a neutral stance to parents so they can see themselves and their situation more impartially

So what do PSPs actually do? While each system of care is unique, some duties can be commonly found in many F2F peer support programs. Among these, PSPs

- Link families to appropriate services and supports and help families access them.
- Promote partnerships between parents and service providers.
- Help families navigate complex service systems and bureaucracy.
- Assist parents in identifying their child's needs and develop effective solutions to address them.
- Help family members make informed decisions.
- Serve as advocates for the family within the system(s) and facilitate conflict resolution.
- Assist in the development of parent goals.

- Help parents find natural supports.
- Serve as mentors and role models.
- Provide emotional support.
- Instill confidence so that parents understand they are the best advocates for themselves and their children (NFFCMH, 2008; NFFCMH, 2012; CHCS, 2014; Harris, 2014; Jones et al., 2014).

This list is by no means comprehensive. Additional duties can range from providing transportation, to advocating internally for systems transformation, to helping families secure basic needs, and much more.

Just as it is important to define what PSPs do with families, it is equally important to clarify what they do *not* do. PSPs do not provide clinical services. Frances Purdy, who has written and presented extensively on the subject, states, "Parent support is not a clinical service. It is a peer-to-peer service. The relationship is based on the strategic sharing of their own parenting, knowledge of navigating helpful systems, and other relevant life experiences" (Harris et al., 2014a, p. 13). As we will discuss later, this distinction is important for organizations to make clearly and early on in order to avoid confusion—and even tension—among staff. Harris et al. (2014a) help distinguish between the two in *Table 1* (p.13).

> **Parent support is not a clinical service. It is a peer-to-peer service. The relationship is based on the strategic sharing of their own parenting, knowledge of navigating helpful systems, and other relevant life experiences.**

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TABLE 1: DIFFERENCES BETWEEN CLINICAL AND PARENT SUPPORT	
Clinical	**Parental Support**
Assesses strengths and difficulties of individual	Models hope, shared decision making, and wellness
Assists individuals to identify reasons why individual has repeated…actions/reactions	Supports individual to identify goals and needs
Teaches/directs/supervises chosen remedies	Assists individual to find and assess information for decision making

Most importantly, according to Purdy, is remembering that PSP lived experience can serve as a source of unique support not found elsewhere in the children's mental health service array. She states, "We're not engaging parents. Parents are already engaged. What we are doing is supporting parents" (Harris, King, Purdy, & Wells, 2014b).

Why F2F Peer Support? Intended Benefits and Actual Outcomes
The philosophy behind embedding PSPs into an existing service array fits squarely into system of care core principles. PSPs promote family-driven and youth-guided systems because "once parents understand their own children's needs and best practices to address those needs, they can choose the right type and amount of treatment necessary" (NFFCMH, 2012, p.1). By tapping the expertise of family members who have gone through the same system of care, F2F peer support is both community based and culturally competent. As Munson et al. (2009) explain, PSPs "provide a workforce that is culturally aware of the needs of family members since they have similar experiences and come from the same community" (as cited in NFFCMH, 2012, p. 2).

Many systems of care have looked to F2F peer support services to help attain positive benefits for their families. Belinda Harris, lead parent advocate at Cuyahoga Tapestry System of Care in Ohio, says some of the assumed benefits between service providers and families include (1) making engagement easier and more effective for staff and families, (2) helping teams hear family needs more effectively, (3) better preparing families for the team planning process, and (4) generating better solutions to family needs (Harris et al., 2014a).

Other anticipated benefits to the family members are equally promising. Obrochta et al. (2011) say that among these are decreasing family isolation and internalized blame, increasing awareness of the importance of self-care, increasing feelings of self-efficacy, and increasing a family member's ability to work with both formal and informal support.

With such high expectations placed on the benefits of F2F peer support, the questions remains, "What are the *actual* outcomes of this type of service?" For years, champions of the F2F peer support movement implored systems of care to implement stricter data collection and evaluation techniques, fearing future opportunities for growth and funding would be missed without adequate data on outcomes. (See NFFCMH, 2008; and Hoagwood et al., 2009, and Robbins et al., 2008, as cited in Obrochta et al., 2011.)

More and more research has emerged in recent years. A literature review of recent research on family and youth supports highlighted growing evidence that F2F peer support programs have positive outcomes. Outcomes included:
- Peer support programs help parents who have children with special needs find and become reliable allies for each other.
- Parent-to-parent support programs are valued by parents and may improve the emotional functioning of parents who have children with disabilities and help them improve their coping skills.
- The self-efficacy and empowerment of families can be enhanced by providing family support, and this has been associated with a variety of improved outcomes such as service initiation and completion, increased knowledge about the youth's condition and relevant services, satisfaction, and youth functioning at discharge.
- Parents displayed a greater increase in hopefulness and were overwhelmingly satisfied with their experiences.
- There is encouraging initial evidence of….reducing child symptoms and improving child functioning. Furthermore, there is evidence of some benefits to the parents and caregivers, including a reduction of stress, improved mental health and wellbeing, perceived social supports, and increased treatment engagement (CHCS, 2013, p. 1–3).

Such significant and promising research has caused systems of care to take notice. Additionally, some involved with implementing F2F peer support services make the case that the intangible benefits may be the most compelling of all. Malisa Pearson, project coordinator at the Family-Run Executive Director Leadership Association, states, "Because you

TABLE 2: STATES WITH PEER SUPPORT INCLUDED IN THEIR MEDICAID STATE PLAN (AS OF JULY 2014)
Alaska
Arizona
Colorado
Connecticut
District of Columbia
Georgia
Illinois
Indiana
Iowa
Kansas
Kentucky
Maine
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Nevada
New Jersey
New Mexico
North Carolina
Ohio
Oklahoma
Oregon
Pennsylvania
South Carolina
Tennessee
Texas
Utah
Virginia
Washington
Wisconsin
Wyoming

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share the lived experience, you speak the same language and it's different. There's a different level of trust when families talk to other families. There's something very powerful that happens when you connect with someone who has lived through that same experience" (Spencer et al., 2014b).

What Is Needed to Implement F2F Peer Support Services
With such increasingly compelling evidence on outcomes, it is no wonder tribal systems of care have such high interest in incorporating formal F2F peer supports into their service array. Fortunately, tribal communities now have the benefit of drawing upon lessons learned by those organizations that have undertaken this work before them.

F2F peer support services require an organization to have the capacity to build infrastructure that will adequately support these new services. Highley et al., (2014) correctly emphasize two central questions that all systems of care considering F2F peer support must ask: (1) Is our organization ready? (2) Are our consumers ready? More specifically, just to begin considering whether to offer F2F peer support, systems of care must
- Determine what organizational model they will adopt.
- Assess what funding opportunities can support the work.
- Articulate complex policies and practices that are needed to accommodate F2F PSPs and define their terms of employment.

Organizational Model
Obrochta et al. (2011) point out that organizational models that have been used to implement F2F services "vary in the scope of services offered, PSP training and other workforce issues, and reimbursement mechanisms" (p. 2). Still, much of the work developing F2F peer support services to date has been championed by independent, family-run, nonprofit organizations. PSPs are hired as employees of the family-run organizations, and then work in tandem with children's mental health agencies in coordinating care. Such precedent creates an interesting challenge for tribal systems of care that, by and large, have opted *not* to create family-run nonprofits and would therefore need to identify a different organizational model to use. (See *Special Considerations for Tribal Systems of Care*.)

Funding
Regarding funding, F2F peer support services have historically been funded with a creative and diverse number of blended funding streams. Among the funding sources cited are
- Federal mental health block grants to states, child welfare agencies, and local, state and federal grants and cooperative agreements (NFFCMH, 2008).
- State appropriations and federal Title IV-B funds (CHCS, 2014).
- State general revenue funds, Medicaid service delivery and administrative case management dollars, federal discretionary grants, and fee-for-service activities reimbursed by various entities (Obrochta et al., 2014).

As indicated, Medicaid is often cited as a funding source for F2F peer support. Indeed, "F2F peer support activities often can be funded through Medicaid if they are medically necessary, are consistent with the child and family plan, and are provided by a PSP who is approved by the state Medicaid authority or supervised by a licensed or certified individual" (Obrochta et al., 2011, p. 3). Current Medicaid funding sources for family and youth peer support include the use of state plan amendments, Medicaid waivers, and Medicaid administrative match (CHCS, 2012).

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Guiding Principles and Values of a Sound Support Provider Program

- Representatives of the lived experience must be valued as visionaries, missionaries, and pioneers and the potential of their position should be built upon common values, expectations, and goals.
- A responsibility of the position of the support provider is to question the status quo.
- Success of the program will require flexibility with appropriate and creative accommodations.
- Support providers from diverse communities (rural, urban, socio-economic status, culture, education) must be actively recruited in order to ensure that all invested populations are represented.
- Positions have to be up high enough in the organization to make a difference.
- Networking is critical to doing the job and it should be included in the job description and should be a supported component of personal development.
- The guiding principles of family-, consumer-, and youth-driven care must be explicitly stated and integrated into each activity and effort.
- Different individuals bring different strengths—not everyone can do all "peer support" jobs.
- Accountability and responsibility is a two-way street.
- Support providers are not exempt from the "typical" expectations for staff in the work place in relation to conduct and performance, but they may require accommodations in order to meet those expectations.
- Programs and their staff must make a paradigm shift in their attitudes toward the individuals they serve, recognizing their value as members of planning and treatment teams.
- Family, consumer, and youth representatives who aspire to serve as a partner with professionals must build their skills, capacity, and ability to serve as a professional with expected outcomes, competencies, and standards of performance.
- Failure is not an option, but ongoing adjustments that reflect program growth are expected.

(Source: Wells, 2014, p. 1)

However, differences in state Medicaid plans further complicate matters. As NFFCMH Parent Support Provider Certification Initiative Director Lynda Gargan explains, "Peer support services are now included in the Medicaid state plans in 32 states and the District of Columbia (see *Table 2*), many as part of the rehabilitation option. These services for many states cover adults only. [However] in May 2013, a joint bulletin was released by the Center for Medicare and Medicaid Services and the Substance Abuse and Mental Health Services Administration that confirmed the inclusion of families and youth in the definition of 'peer'" (Spencer et al., 2014a, p. 2).

In 2012, the CHCS published an elaborate summary of state strategies for funding formal family and youth peer support through their Medicaid plans that illustrates just how diverse such strategies are from state to state. (See CHCS, 2012. Also found under *Additional Resources*.)

Some who have launched F2F peer support services strongly encourage examining all possible sources of funding, along with identifying a comprehensive budget for new services, to determine if the costs of F2F peer support can realistically be covered.

Policies and Procedures
Determining organizational capacity to implement F2F peer support also requires an assessment of the adaptability of existing policies and procedures. Specifically, new personnel practices must be developed to accommodate PSP staff qualifications and experience. Systems of care must have the policies and procedures in place to address barriers that often get in the way of PSP success. Common among these are PSPs' need for flexible work hours, ongoing training, transportation assistance, and child care. Hiring practices are also complicated. Sometimes, policies exclude the hiring of those with a criminal record, even if their subsequent life experience would make them perfect for a PSP position.

If Medicaid is to be pursued as a source of funding, systems of care must have the correct policies and procedures in place for it. The CHCS (2014) emphasizes, "Becoming a Medicaid provider may require an organization to overhaul its existing policies and procedures, as well as modify the services currently provided and the population of families served" (p. 6). Medicaid billing policies and procedures are very specific, requiring organizations to have staff dedicated to billing functions and organizational procedures around documentation, training, and billing.

It is worth noting that adding PSPs to the formal service provision team also requires systems of care to determine in what capacity they will "work" for the agency. Often this decision may be dependent upon capacity and resources available, but

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TABLE 3: EMPLOYEE, CONTRACTOR, OR VOLUNTEER		
Type of Pay	**Benefits**	**Considerations**
Employee	• Official staff person • Benefits provided • More oversight and control • Capacity to provide a career ladder • Office space and equipment • Standardized orientation • Feels more like a team member • May cost the program less	• Responsible for accommodations • Benefits and pay may interfere with [PSP] eligibility for supports and services [if the PSP is continuing to access services and those services have income eligibility rules] • Must provide supervision • Accommodations may cause tension with other…staff • Pay scale protocol for non-licensed staff may be too low
Contractor	• More flexibility in hours • More flexibility in pay and schedules • Can better protect [PSP] participation in income-eligible programs [if benefits and pay don't exceed the eligibility thresholds for those progams] • More independence with less programmatic restrictions	• [Less control over] support provider readiness • IRS regulations • Decreased supervision capacity • Contract may be less permanent • Pay and reimbursement may be inconsistent and delayed
Volunteer	• Low or no cost • Gives an opportunity to "pilot" the program • Gives staff time to get acclimated to the position • Provides an opportunity to grow and nurture potential employees for the future	• You get what you pay for • Ongoing capacity development may not be a priority • The position may not be seen as "real" • Mandating protocol may be more difficult • Participation may be more intermittent and not a true reflection of a formal support provider program

experienced F2F peer support experts warn that how PSPs' roles are defined will have lasting repercussions. It affects how systems must develop and establish pay methods and rates for PSPs, which are often based upon professional trends, experience, scope of work, job description, and certain IRS regulations.

Wells (2014) highlights the pros and cons of retaining employees, volunteers, and contractors for the PSP role in *Table 3* (p. 2).

Such considerations are by no means comprehensive, but they do give some indication of the extensive ground work that must be done in order to embrace the F2F model. Once a system of care has determined it has the capacity to accommodate these types of demands on resources and infrastructure, it can move toward the actual nuts and bolts of implementing F2F peer support.

We're Ready, Now What Do We Do?
While every system of care is unique, the literature and testimonials of those who have been involved in developing F2F peer support again draw some parallel conclusions about what it takes to bring on and keep a successful staff of PSPs. They point to the following steps:
• Recruit
• Train
• Supervise and Support
• Retain and Sustain (Wells, 2014; Jones et al., 2014; Purdy, 2010; Highley, 2014)

Recruiting
Because PSPs are non-clinical staff whose primary qualification is having lived experience raising a child with emotional, behavioral, and mental health challenges, recruitment for such positions requires reaching out to a limited pool of possible candidates. In addition, experts are emphatic that having a lived experience alone does not automatically make someone a

good PSP. The NFFCMH elaborates, "The job requirement is not just being or having been a parent, it is that ability to articulate and model lessons learned from those experiences. The fundamental or essential job duty of the PSP is to be a role model. Individuals need to show empathy and day-to-day practical examples of how a parent will learn to use the same skills" (NFFCMH, 2011, p. 1).

So what are the characteristics of an effective PSP? Gargan lists having effective listening skills, being collaborative, adaptable, non-judgmental, resourceful, creative, respectful, a positive problem solver, and able to maintain confidentiality among key traits (Spencer et al., 2014a, p. 8). Others emphasize the need to be "well versed in the community, continuum of care, and the social contexts affecting wellness" (Purdy, 2010, p. 1).

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The Futures Program at Truman Medical Center in Kansas City, Missouri, has developed a simple checklist (*Table 4*) to help determine if a former consumer of services is ready to take a more active role as a service provider.

This recruitment process may seem like a lot to undertake, especially for small tribal communities where the number of potential candidates is limited. However, North Carolina Families United Family Support Director Elizabeth Jones explains the challenge isn't in locating possible candidates. Rather, it is in convincing former service recipients that they are uniquely qualified to provide an invaluable service to other families. She states, "The more you help people see they have some very valuable knowledge, the more willing they are to help" (Jones et al., 2014).

Training

Training PSPs is essential, ongoing, and time- and resource-intensive. Longtime children's mental health advocate Conni Wells explains that successful PSP training establishes mutually agreed upon expectations, creates an environment of involvement, develops program readiness, enhances PSP capacity, and improves a program across all levels (Harris et al., 2014a, p. 10).

Training of PSPs varies greatly among systems of care. Tiffany Sturdivant from Truman Medical Center Behavioral Health explains that PSP training often must begin with fundamentals. She states, "You need to make sure they have a clear understanding of what the [PSP] role is supposed to be. For some, this is their first professional job. There are a lot of soft skills that we learned that our peer specialists weren't aware of, like dress and time management" (Highley et al., 2014). Others have found that PSPs need to be trained on subjects like establishing boundaries in the PSP-parent relationship, case review, and balancing advocacy and empowerment, to name a few.

As the F2F peer support movement has evolved, there has been increasing emphasis on the need for intensive training around PSP core skills such as "oral and written communication, mentoring, advocacy, knowledge of the local children's system of care, team facilitation, confidentiality, and ethics" (Obrochta et al., 2011, p. 7). Beyond these skills, PSPs may be trained in much more complex core competencies. For example, North Carolina Families United requires their PSPs to complete 80 hours of training on topics such as Triple P[3], trauma-based cognitive behavioral therapy, and motivational interviewing. In addition to the 80 required hours of training, they offer 20 optional hours every year.

Other considerations may factor into what formal training is required of PSPs. Specifically, more and more family-run non-profit organizations are requiring their PSPs complete state or national certification. (See *Certification of Peer Support Providers*.) Those receiving Medicaid funding may be required to train PSPs on Medicaid rules on documentation (includes writing notes, developing support plans, and composing monthly summaries), administration, and how peer support complements clinical services (CHCS, 2014).

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3 Triple P, or Positive Parenting Program®, is an evidenced-based parenting program designed to prevent and treat behavioral and emotional problems in children and teenagers. See www.triplep.net.

TABLE 4: CONSUMER READINESS	
Ready	**Not Just Yet**
Has a passion to lead and create change based on their positive and/or negative experiences	Still angry with "the system"
Accepted what they have been through; Can use their experience to role model and create change; If they are still angry, can use that energy assertively	If they are still angry about experiences with a clinical staff or family member or peer, their anger gets in the way of trying to be assertive
Able to separate personal life circumstances from that of their clients	Difficulty generalizing their experiences, difficulty understanding why someone may choose a different path, wants to be "too" helpful
Understands when to strategically use their life story	Telling their life story as a means of catharsis, is reliving the experience as with post-traumatic stress disorder, or for secondary gain
Has coping skills to manage secondary trauma	Work stress is close to potential stressors at home, difficulty separating the two
(Source: Highley, 2014, p. 13)	

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Such training requirements may feel burdensome to PSPs. The CHCS (2014) elaborates, "This can be challenging for individuals who provide excellent family support, but may not have the educational or related work background" (pp.15–16). Fortunately, there are ample resources within the systems of care and broader children's mental health network that provide curricula, training toolkits, and other professional development tools. (See *Additional Resources*.)

Supervising and Supporting

At the recent peer support workshops and institutes offered at the Georgetown University Training Institutes in July 2014, presenters repeatedly used the term "culture shift" to describe what needs to occur in order to successfully implement F2F peer support services. Nowhere was this more apparent than in their explanations of the PSP-supervisor relationship. Highley (2014) states, "You aren't just asking a consumer to come to a meeting or two, or attend a council one night a month. Increasing consumer involvement requires planning and strategy, but will require a culture change" (p. 6).

As described earlier, embedding PSPs into the service array requires different infrastructure than more traditional systems of care. Supervisors are tasked with developing and implementing an adequate training plan for PSPs, understanding financial procedures around client billing and PSP payment, coordinating service provision across multiple teams, fostering staff buy-in for the shift in services offered, and retaining talented staff. For each responsibility, they need to be supported by system infrastructure.

Obrochta et al. (2011) recognize that "blending personal experience with a professional role requires unique and dedicated organizational supports" (p. 4). They offer some suggestions in how to begin clarifying roles and responsibilities, stating, "Clearly specified staff qualifications and job requirements, staff training, support, and supervision are needed. The role of PSPs needs to be clearly communicated with other service providers and agency staff to avoid misunderstandings or unrealistic expectations" (p. 4).

Wells warns that PSP supervision also requires a new kind of organizational flexibility. Systems of care adding PSPs to their staff should be prepared to make accommodations. These could include
• Allowing PSPs to work from home or telecommute.
• Allowing flexible work hours.
• Developing work schedules that consider and accommodate school or family holidays and vacations (Harris et al., 2014a).

Spencer et al. (2014a) add that there are other unique challenges to supervising the lived experience workforce. Maintaining professional boundaries and confidentiality are among these. They explain, "PSPs often utilize the same services and supports for their own children that are used by the parents they are helping. This raises a number of logistical concerns. How can the privacy of the children, youth, and other family members of the PSP be protected? Can coworkers socialize with a PSP in the same manner they socialize with other coworkers since they, their child, or their family member might become recipients of services and supports from the agency" (p. 6)?

Spencer et al. (2014a) remind us that PSPs "come from all types of backgrounds. They have common competencies and experiences as parents and caregivers. Some have very minimal formal education but have extensive experience in coordinating services and supports for their children. Some have advanced degrees. Some have their own emotional, behavioral, or mental health challenges" (p. 6). Not surprisingly, PSP supervision requires a lot of coaching.

Sturdivant agrees, citing an example with one of the PSPs employed within her program. "The Department of Health has very strict guidelines as far as how they want us to document," she explains. "Peer support specialists, because they are integrated into the mental health system, have to document the same way. One of the things she wanted to work on was learning how to sound professional, how to use correct grammar [in her documentation]. In situations like those, you have to learn how to coach and be patient" (Highley et al., 2014).

One of the more significant challenges to fostering a culture shift is the difficulty other staff experience in accepting and valuing the integration of PSPs into the continuum of services. Some staff members who may be accustomed to more traditional clinical roles sometimes encounter great difficulty in valuing former clients as colleagues or perceiving services delivered by PSPs as having equal stature.

For example, Sturdivant shares how such a blurring of roles can impact the hiring process. She states, "With one agency we noticed that some of the staff had a hard time separating the internal candidate who was a parent who hadn't always shown up for all the appointments for their child. They couldn't separate who they were as a parent versus now they were also a coworker" (Highley et al., 2014).

Special Considerations for Tribal Systems of Care

As noted throughout this issue, undertaking a rigorous and honest system assessment is the requisite first step for any tribal system of care who is considering developing family to family (F2F) peer support services. The difficult challenges emphasized by current F2F program staffers are compounded in Indian Country for many reasons unique to tribal communities. The enhanced infrastructure and capacity needed to recruit, hire, train, retain, and bill peer support providers (PSPs) may tax already underfunded tribal systems. Small, rural communities comprised of closely-related families could intensify challenges around boundary-setting and confidentiality, not to mention the smaller candidate pool from which many Native communities have to draw.

More significantly, however, are the challenges presented by two key components of infrastructure that other communities have used to help launch their programs: family-run nonprofit organizations and a behavioral health Medicaid billing capacity. First, the family-run nonprofit organizations that have championed this movement (and very often serve as independent implementers of PSP programs) are almost entirely absent in tribal communities. The emphasis that many place on the essential role of these organizations cannot be overstated. In fact, the NFFCMH (2012) concluded, "A key finding of the literature and qualitative secondary data analysis is that having family involvement at the system level *requires* an engaged, locally developed, autonomous family organization that is regarded as an equal partner agency within the system" (p. 2) [emphasis added].

Second, although improvements are being made, many tribal communities have yet to establish a Medicaid billing capability for their behavioral health services. The reasons behind this are numerous and very complex. For example, tribal systems of care may not be connected to other medical providers, and therefore would need to build their own billing infrastructure. The technical expertise needed to do so may stretch beyond the current capacity of many tribal systems of care. Also, some state plans do not give tribes many avenues to become Medicaid providers, despite calls for changes to these policies.

Despite the lack of these two key components in many tribal systems of care, Native communities may still overcome these challenges. It is important to recognize that Native communities already value key elements embodied in the PSP philosophy. Tribal communities rely upon strong, intimate family-to-family support networks in promoting the health of their children. Formalizing these roles may not be as large a culture shift in Indian Country as it has been elsewhere. Also, tribal communities can benefit from the growing research and information that now exists to avoid the costly pitfalls experienced by others. Furthermore, models of peer support are already emerging in other programs in tribal communities, specifically within many tribal Temporary Assistance for Needy Families programs.

Highley (2014) warns, "Before going all in, an organization must take a full inventory of both the benefits and risks of increasing peer/consumer involvement. As with anything worth doing, there will be road blocks along the way. In order to make a commitment to increasing peer/consumer involvement, an organization must be prepared to meet those risks as they arise" (p. 5). Tribes should indeed take note of such advice. At the same time, there is no reason to believe that tribal systems of care will not address these challenges the way they always have—by learning from the broader network, adapting promising models to fit true community needs, and providing the resulting culturally relevant services to tribal families.

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Sturdivant's example demonstrates just how complex integrating PSPs into systems of care can be. At the foundation, a supervisor has to know and value the lived experience, while a PSP needs to understand and value clinical work. As Harris asserts, "It's not enough to hire parents, you should pair hiring parents with a change in practice…a total system overhaul" (Harris et al., 2014a, p. 2).

Retaining and Sustaining

It takes planning and effort to retain talented staff. For systems of care, there are special considerations in retaining PSPs. In addition to the need for institutional flexibility, supervisors and colleagues need to be aware that PSPs may be

(continued from page 9)

unaccustomed to the professional work environment they take for granted. Harris et al. (2014a) elaborate, "If the workplace is like living in a foreign country—not knowing anyone,

> **Entering into the F2F peer support arena requires nothing short of a paradigm shift in children's mental health serving tribal communities.**

not understanding the language and rules, or feeling different—the support provider will not stay. Money will have been wasted" (p.10).

Sturdivant adds, "We need to make sure that we don't minimize the role. One way to combat tokenism is to make sure you have areas of advancement for your peer staff, that they have access to the clinical ladder just like your other staff" (Highley et al., 2014). Obrochta et al. (2011) similarly describe how creating such trajectories for growth is quickly becoming recognized as a best practice in the field, stating, "There is recognition of the need for career paths for PSPs so that there are clear opportunities for advancement into managerial and leadership roles" (p. 7).

Finally, those familiar with F2F peer support programs share common experiences on what it takes to sustain these services. Beyond the constant search for diversified funding streams, experts point to the impact that formalizing a commitment to the culture shift and rewarding staff dedication play in a program's success. Others share why recruitment of talented team members is constant, explaining, "Organizations with a successful peer/consumer component are always recruiting. Why? Young people move away. Go to college. Adults have other commitments. They find full-time work. Recruit, recruit, recruit" (Highley, 2014, p. 27).

Conclusion: Lessons Learned and Possibilities for Indian Country

For tribal communities that wish to enter the F2F peer support movement, it bears repeating two central questions mentioned earlier. Is your organization ready? Are your consumers ready? From building a strong and stable infrastructure to support a PSP workforce, to building a plan to sustain new services, it is clear that entering into the F2F peer support arena requires nothing short of a paradigm shift in children's mental health serving tribal communities. In other words, it is not to be undertaken without careful planning and consideration. However, if the answer to those two questions is yes, then tribal communities stand to benefit greatly from not only the decades of lessons learned by trial and error in the broader system of care community, but also from the benefits to parents, families, and children that research indicates is increasingly substantial.

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Certification of Peer Support Providers

With increasing frequency, children's mental health systems are requiring state and national peer support provider certification as they seek to apply high and uniform performance standards to an emerging lived experience workforce. Tribal communities contemplating employing peer support providers (PSPs) within their system of care will need to consider whether adding a certification requirement into their PSP eligibility criteria is feasible for them.

In September 2012, the Center for Social Work Research published a comprehensive overview of state peer support training and certification programs and found that 36 states had established such programs (see Kaufman et al., 2012). However, many of these states may only certify PSPs for *adult* mental health services. States that have a certification process for adult-to-adult peer support may have not yet created a certification process for youth. Also, certification requirements vary from state to state.

> **National certification also requires completion of 1,000 hours of experience performing parent support tasks, agreement to abide by the code of ethics, receiving a passing score on the national examination, and re-certification every two years.**

The National Federation of Families for Children's Mental Health (NFFCMH) has created a national certification process specifically aimed toward parents and families of children with emotional, developmental, behavioral, substance use, or mental health challenges. In 2007, the Certification Commission for Family Support—an independent body operating within the NFFCMH—began collecting and examining information on PSPs from programs nationwide. They formed a work group that used the information to develop standards of core competencies that would be used in a national certification program. Their PSP certification process began in late 2011, with the first certificates awarded in June 2012.

To be nationally certified, PSPs must provide a description of their lived experience of parenting a child who has experienced social, emotional, and/or behavioral challenges. In addition, they must complete eight contact hours of training in each of the 11 competency domains (or have equivalent on-the-job training). The domains are:

1. Ethics
2. Confidentiality
3. Effecting change
4. Behavioral health treatment
5. Educational information
6. Communication
7. Parenting for resiliency
8. Advocacy
9. Empowerment
10. Wellness and natural supports
11. Local resources

National certification also requires completion of 1,000 hours of experience performing parent support tasks, agreement to abide by the code of ethics, receiving a passing score on the national examination, and re-certification every two years (Spencer et al., 2014). For more information on national certification, visit http://ffcmh.org.

Proponents of certification assert that it "promotes ethical practice and creates mobility of workers across states. It brings to the workforce parents with experience in successfully helping their own children and increases the acceptance of this effective 'modern and good' or best practice...The overall goal is to decrease the stigma associated with behavioral health challenges and promote effective strength-based children's services that are family-driven/youth-guided" (NFFCMH, n.d.).

The Certification Commission for Family Support further states that using a nationally certified PSP will yield positive outcomes for parents that include:

- Positively accessing and being engaged in the treatment and educational services for their child
- Understanding children's health and well-being
- Experiencing less parental stress
- Increasing the resiliency skills of their child
- Increasing the chances their child will graduate from high school
- Reducing the use of expensive hospitalization and long-term residential treatment (NFFCMH, n.d.)

With so many positive outcomes, why wouldn't a system of care pursue certification of its PSPs? For many organizations, it's a matter of capacity and resources. Certification test fees can add up. While it is true that 65% of states have no cost for their certification, of those states who do charge, 60% have a fee of $200 or more (Spencer et al., 2014). The national certification examination fee is $300; recertification costs $200 every two years.

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Test fees may only be one obstacle. As stated above, national certification requires 88 hours of training and 1,000 hours of direct work experience. Expecting PSPs to complete these requirements by volunteering their time may prove to be an undue financial burden that they are unwilling to undertake. Similarly, systems budgets may not have the capacity to cover the ongoing staff training costs associated with adding PSPs to their staff. As many tribal system of care workers already know, such staff training is not a Medicaid-billable activity.

This dilemma has been cause for some criticism. According to the NFFCMH (2008), "The issue…has become somewhat controversial. Certification processes take time, cost money, and create a certain stratification of providers. Some say it creates an elitist structure preventing those without resources from becoming providers of peer-to-peer support, while others suggest the certification process lends credibility to the role" (p. 10).

Despite these concerns, experts agree that children's mental health systems are trending toward adopting certification as a requirement of their PSPs. Why? The NFFCMH (2008) explains, "The question of necessity is perhaps the most important. Is it necessary for family peer-to-peer support providers to be certified in order to be reimbursed for their services" (p. 10)? The answer to this question is increasingly yes. Medicaid and a growing number of states require that a certification process must be in place if peer support services are reimbursed.

Because certification has the potential to lead to positive family outcomes and may create a Medicaid funding stream to help offset costs, it is not surprising the popularity of such programs is increasing. According to Lynda Gargan, director of the National Parent Support Partner Certification Initiative, as of July 2014, 189 individuals had received national PSP certification. Thirty-five states and the District of Columbia are currently using nationally certified parent support providers in their mental health systems (Spencer et al., 2014). The strong support and interest has also resulted in the Certification Commission for Family Support announcing that they will develop at least three more national certification programs for an expanding array of service providers: PSP supervisors, youth support specialists, and youth support specialist supervisors.

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