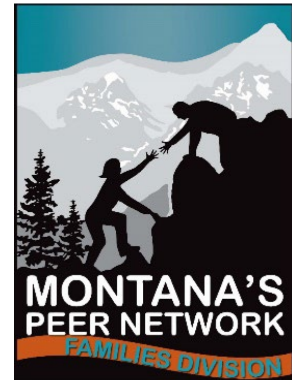
Montana's Peer Network
Family Peer Support Pilot Project
December 2022- September 2024

Introduction



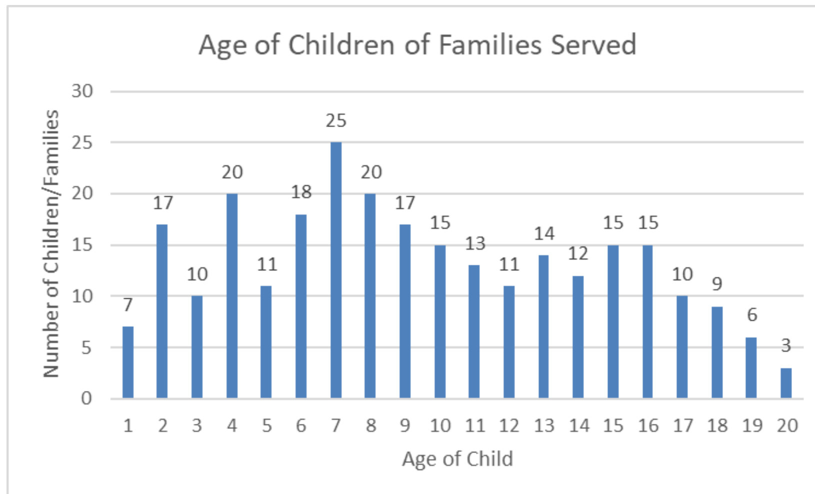
In December 2022, Montana's Peer Network (MPN) began a Family Peer Support demonstration project where Family Peer Supporters provided support to Montana families raising children with special healthcare needs including behavioral health. The objective of the demonstration project was to develop a model for Family Peer Support, develop appropriate training, and seek sustainability of Family Peer Support Services. For the project Family peer support was provided in-person, by phone, or virtually with referrals from the three on-site locations, a state-wide telephone number, and from provider organizations we connected with through outreach. A Family Peer Supporter must have lived experience raising a child with behavioral health challenges and/or special healthcare needs. Three provider clinics and three employees were absorbed by MPN from the previous program.

This white paper is intended to give a breakdown of the demonstration project including goals, their outcomes, how the project was designed and carried out, funding and plan for sustainability, obstacles, case studies, data collection, lessons learned and next steps.

Demonstration project goals:

1. Deliver individual, group, in-person, and virtual Family Peer Support services throughout Montana.
2. Develop a statewide network of Family Peer Supporters, family-led organizations, families, and other stakeholders.
3. Develop and provide standardized training for Family Peer Supporters.
4. Lead the efforts for the sustainability of the Family Peer Support workforce in Montana, including training, funding, and service delivery.

Demographics



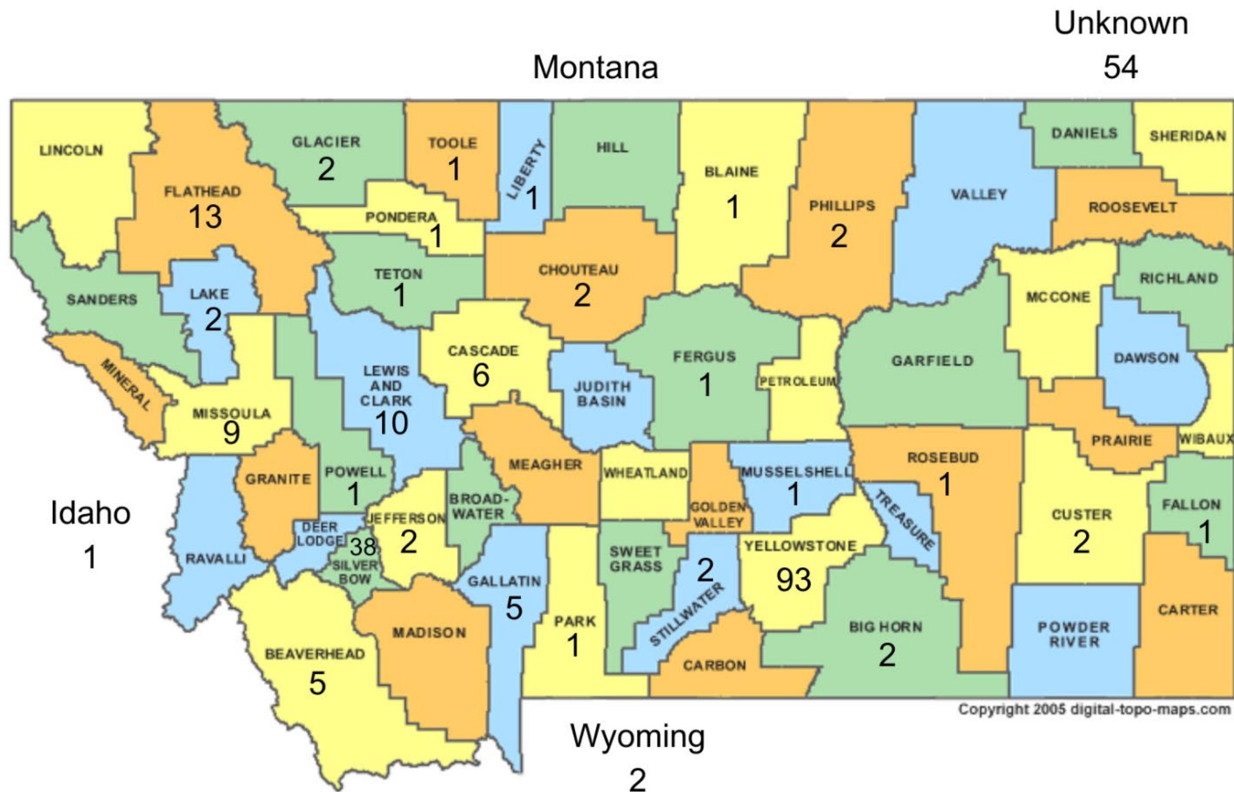
In Montana in 2022, the population of children under the age of 19 was 260,473.[1] According to a statewide needs assessment by The Family & Community Health Bureau, 19% of Children in MT have a special healthcare need.[2] Using these figures, there are approximately 49,489 children in MT with special healthcare needs whose families would benefit from Family Peer Support. During this 2-year demonstration project, we served 268 families. There is an unmet need in Montana for Family Peer Support. Although not all the families of the 49,489 children with special healthcare needs would utilize Family Peer Support services, only .5% of these families were served during this 2-year project. More Family Peer Supporters are needed to adequately serve Montana families.

Family Peer Supporters worked with the parent or caregiver which included biological parents, foster parents, grandparents, and other caregivers. The following is a breakdown of who was served in this project according to their relationship to the child:

- Mothers 85%
- Adoptive parents 5%
- Fathers 4%
- Other family members/caregivers 2%
- Both parents 1%
- Fathers and Stepmothers 1%
- Grandparents 1%
- Guardians 1%

[1] https://www.marchofdimes.org/peristats/data?reg=30&top=14&stop=178&slev=4&obj=9&sreg=30
[2] https://mchb.tvisdata.hrsa.gov/Narratives/IIBFiveYearNeedsAssessmentSummary/50a3882e-43c3-415b-9688-63bef302ab61

Number of Families Served by County



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Location	**Length of Time Project was Operating**	**Number of Family Peer Supporters**
Billings	24 months	2
Butte	6 months	1
Shodair Genetics (statewide)	12 months	1
Great Falls	3 months	1

Yellowstone and Silverbow counties had the highest number of families served. This correlates with the above table in that Billings is in Yellowstone County and Butte is in Silverbow County. The project ran the longest in Billings for 24 months and had 2 Family Peer Supporters. The location where the project ran the second longest was Butte for 6 months. Had the project run longer in the other locations with more Family Peer Supporters, the number of families that received Family Peer Support in those geographic areas would also have been higher. There were 54 families served whose county of residence was unknown either because the data was not

collected, the family was unwilling to disclose, or the Family Peer Support was unable to collect a signed consent form or only met with the family once.

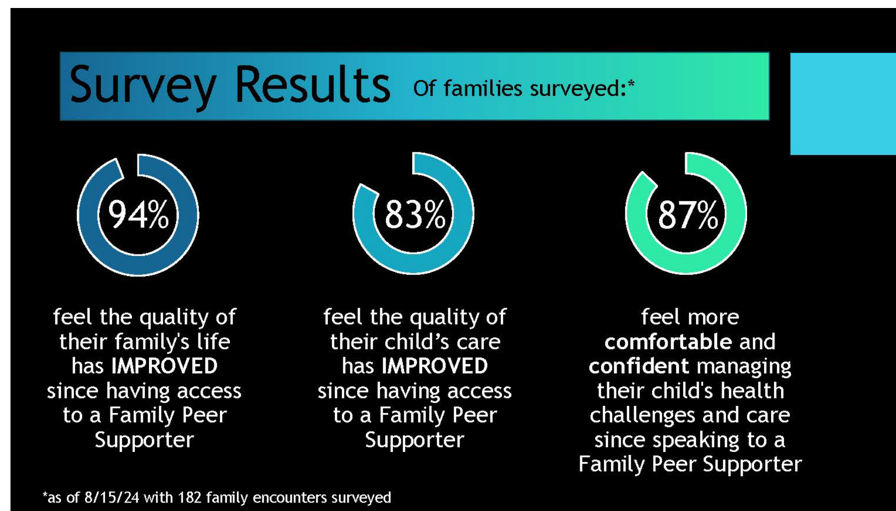
27 out of 56 or 52% of counties in MT were served by this demonstration project. It is our opinion that if additional funds were allocated for Family Peer Support all counties could be provided Family Peer Support. Our project cost was $160,000 per year and we served 52% of Montana counties.

Outcomes

The demonstration project showed great results in achieving goal #1 providing Family Peer Support. Research has shown that parents or caregivers raising children with special healthcare needs reported higher levels of anxiety and depression than their counterparts raising children without these extra needs.[3] Parents express feelings of isolation, judgment, guilt, and stress.

According to the Texas Institute for Excellence in Mental Health, Family Peer Support has been shown to increase family engagement, caregiver knowledge, family empowerment, and social resources and decrease anxiety and family stress.[4] Our survey data results are in line with this.

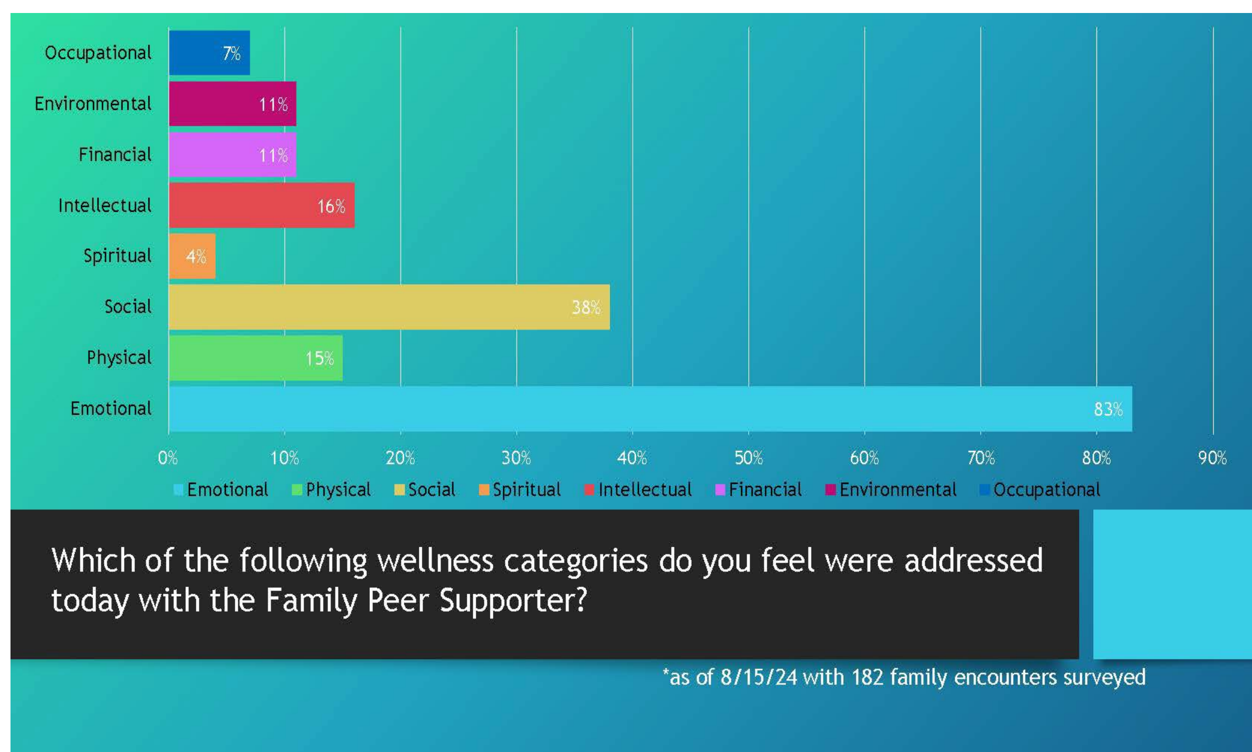
Method used to collect data: Families were sent a link and asked to fill out a short survey after every interaction with a Family Peer Supporter. Surveys were anonymous and contained multiple-choice and open questions.



Note: Family Peer Supporters work directly with the parent or caregiver **not the child**. However, 83% of parents felt the quality of their **child's care** improved. Parents felt better about their child's care and more empowered to advocate for their needs when working with a Family Peer Supporter.

[3] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0219888#pone-0219888-t005
[4] https://sites.utexas.edu/mental-health-institute/files/2016/05/FV-April-5-Infographic.jpg

Family Peer Support encompasses active listening, emotional support, assistance with navigating systems, and connections to resources and community. The core element of Family Peer Support is providing emotional support to parents by building a mutual relationship and connecting through shared lived experience. This is reflected in the chart below. Parents felt Emotional Wellness was addressed most frequently, followed by Social Wellness. MPN's previous demonstration projects with Behavioral Health Peer Supporters showed similar results. Supporting a person's emotional and social wellness fosters empowerment, resiliency, and hope. The chart also shows that all wellness categories can be addressed with Family Peer Support.



Families surveyed were also asked, "If you didn't have access to a Family Peer Supporter, who would you reach out to when you need support or have concerns?" Families could choose from professionals that worked with the child such as child's doctor or child's teacher, professionals that worked with the parent or caregiver such as parent's doctor or parent's therapist, walk-in clinics or emergency rooms, or no-cost options such as friends and family or no one. The top 3 categories that families chose were Nothing/No one, Talked to family or friends, and I don't know. These results shed light on why parents raising children with special healthcare needs express feelings of isolation and loneliness. A graph of this survey question data, the cost of alternative support services, and the financial return on investment of Family Peer Support are further addressed in the data section on page 14.

Project Transition

The Montana Parent Partner Program, providing family support services, operated for 9 years by the Hali Project before MPN was awarded the DPHHS Children's Special Health Services' (CSHS) grant in 2022. At that time, the Montana Parent Partner Program employed 6 Parent Partners across Montana, 4 housed in clinics, 1 remotely connected to a clinic, and 1 community based. The locations were:

- The Children's Clinic, Billings
- Southwest Montana Community Health Center, Butte
- Benefis Hospital Pediatric Specialty Clinic, Great Falls
- Shodair Children's Hospital Genetics, Helena
- Montana Children's Medical Center, Kalispell
- Missoula area

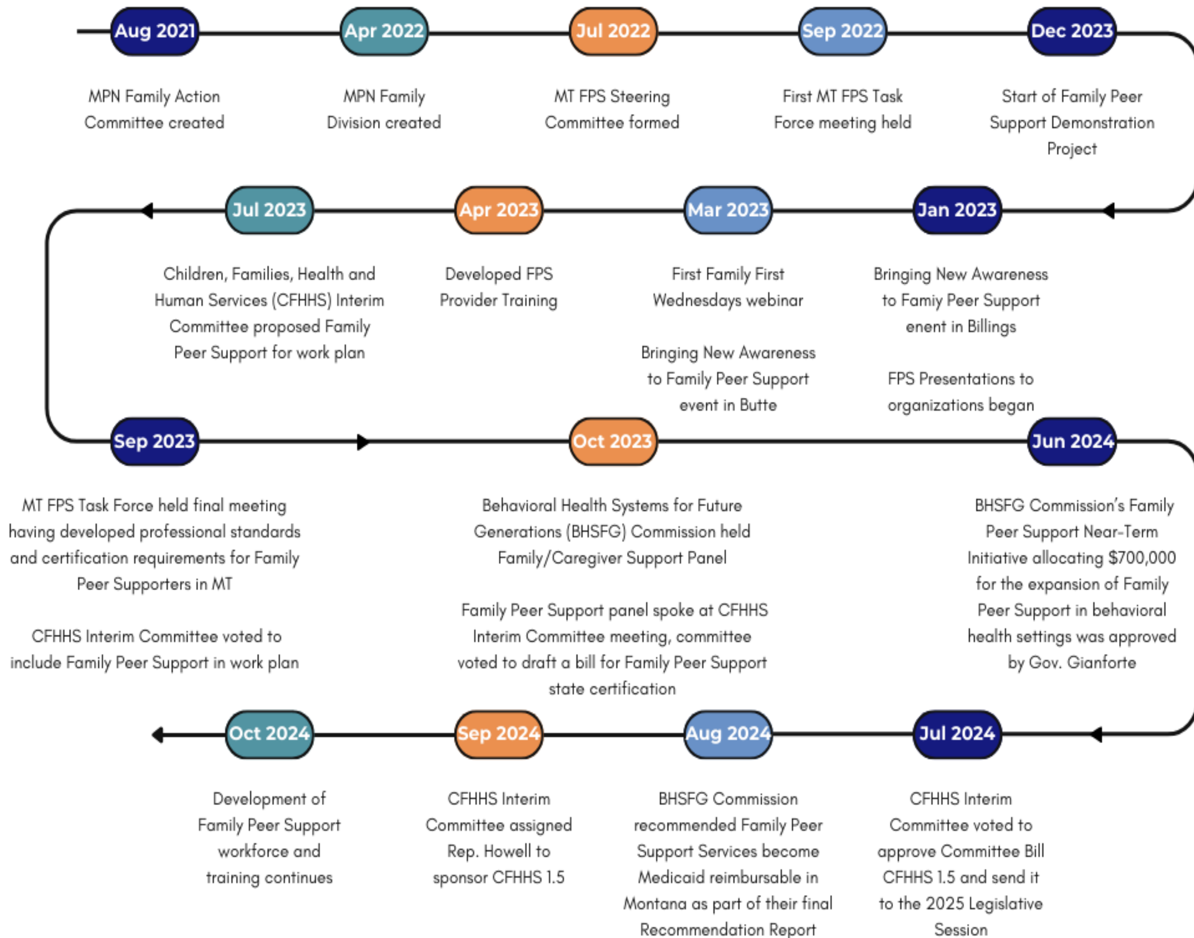
In July 2022, talks began between The Hali Project and Montana's Peer Network to hand off the Montana Parent Partner Program to advance professional development and sustainable funding for Family Peer Support in Montana. The goal of the Hali Project and MPN was to continue the program with MPN absorbing the current Parent Partners and clinic sites under the new contract. MPN leadership met with the Hali Project staff twice before the transition. Brad Thompson, founder of The Hali Project and former Program Director of the Montana Parent Partner Program, contracted with MPN as a consultant to help with the transition. The Hali Project's contract ended September 30, 2022, and CSHS awarded MPN a 2-year contract to begin October 1, 2022. However, MPN did not receive the contract for signature until December 2022 leaving a 2-month gap in the family support services. MPN reached out the Parent Partners and clinic sites during this time but only heard from 3 out of the 6. When MPN was able to begin the project in December, only 3 Parent Partners and 3 clinic sites were absorbed, cutting the program in half. They included The Children's Clinic in Billings, Southwest Montana Community Health Center in Butte, and Shodair Children's Hospital Genetics in Helena.

Montana's Peer Network is a statewide peer run 501c3 non-profit recovery organization whose purpose is to develop a statewide network of individuals who identify as being in recovery from mental health, substance abuse and/or addiction issues or as a family member of a child with behavioral health challenges and/or special health care needs. MPN's mission statement: MPN leads the development of the peer support workforce and creates pathways for wellness and recovery in communities throughout Montana. Historically, MPN has focused on recovery from mental health or substance use but created a Families Division in 2022 to include families raising children with behavioral health challenges or special healthcare needs. MPN is not a service provider but will run demonstration projects to develop and expand the peer support workforce. MPN also provides education, consultation, training, advocacy, and resources using personal "lived experience" through peer support.

Since MPN’s work up to this point had been in behavioral health peer support, it was hard for some of the current Parent Partners to see how serving families with children with special healthcare needs included behavioral health. MPN quickly identified this as an area where education was needed. Behavioral health, including mental illness and substance use disorder, is health and commonly co-occurs with developmental, intellectual, physical, and other disabilities. Behavioral health is also included in CSHS’s definition of a special healthcare need.

Even though the demonstration project remained focused on supporting families with children with special healthcare needs, many aspects of the project changed when MPN took over. MPN is a recovery organization and staff were expected to grow in their wellness through self-reflection and education. Some staff were unable or unwilling to do this. MPN intended to bring professionalism and standards that are in line with the National Federation of Families and SAMSHA national standards to the work by using the nationally recognized model of Family Peer Support. This included a change from focusing more on providing resources to providing emotional support. The focus also changed from being solely on the child to being on the parent or caregiver and addressing their wellness. Family Peer Supporters develop a mutual relationship with the parent instead of being seen as the expert. MPN also learned that some staff had a hard time working within their scope of practice which caused tension with some of the clinic sites and with MPN leadership. MPN also saw a need for the clinic sites to utilize their Family Peer Supporters more. MPN developed Provider Training and met with the clinic sites to address challenges with making referrals, understanding Family Peer Supporters’ scope of practice, and the value peer support brings to the families and how that in turn benefits the clinic and providers. Because of these changes, staff absorbed from the previous project had a difficult time adjusting and chose not to continue with MPN and the Family Peer Support demonstration project.

Timeline



The above timeline shows the various work being done to develop Family Peer Support in Montana.

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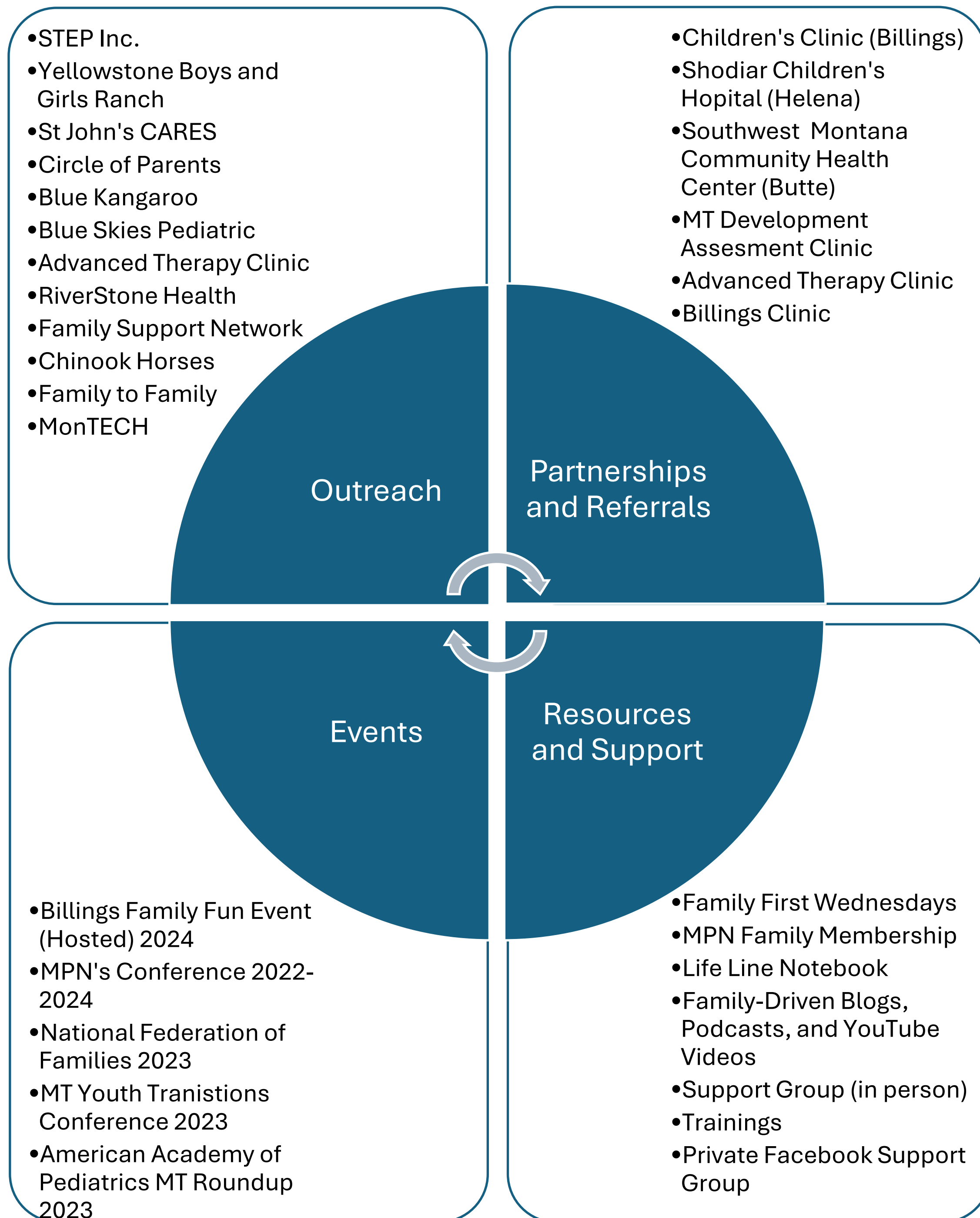
Outreach



Demonstration Project Details

Beginning

MPN's FPS Demonstration Project began by hiring Family Peer Supporters from the previous program and making introductions to their clinic site liaisons. All staff went through orientation and received a work computer and cell phone. Additional staff were hired, and others resigned during the project. Some clinic sites dropped out and referring organizations across Montana expanded. All Family Peer Supporters completed a 40-hour certified Family Peer Support training through Oregon since MT had not developed certification and training yet. Family Peer Supporters also attended Clinical Supervision which is a best practice for peer supporters.

Meetings

MPN held weekly staff meetings and staff education sessions with all MPN staff. A weekly Family Peer Support Team meeting was set up to provide connection between Family Peer Supporters, additional training, and seeking support and guidance on challenges within the job. Leadership met quarterly with liaisons from each clinic site and offered Provider Training to clinic staff. Leadership also met monthly with the funder to discuss the demonstration project and supplied them with quarterly reports.

Documentation

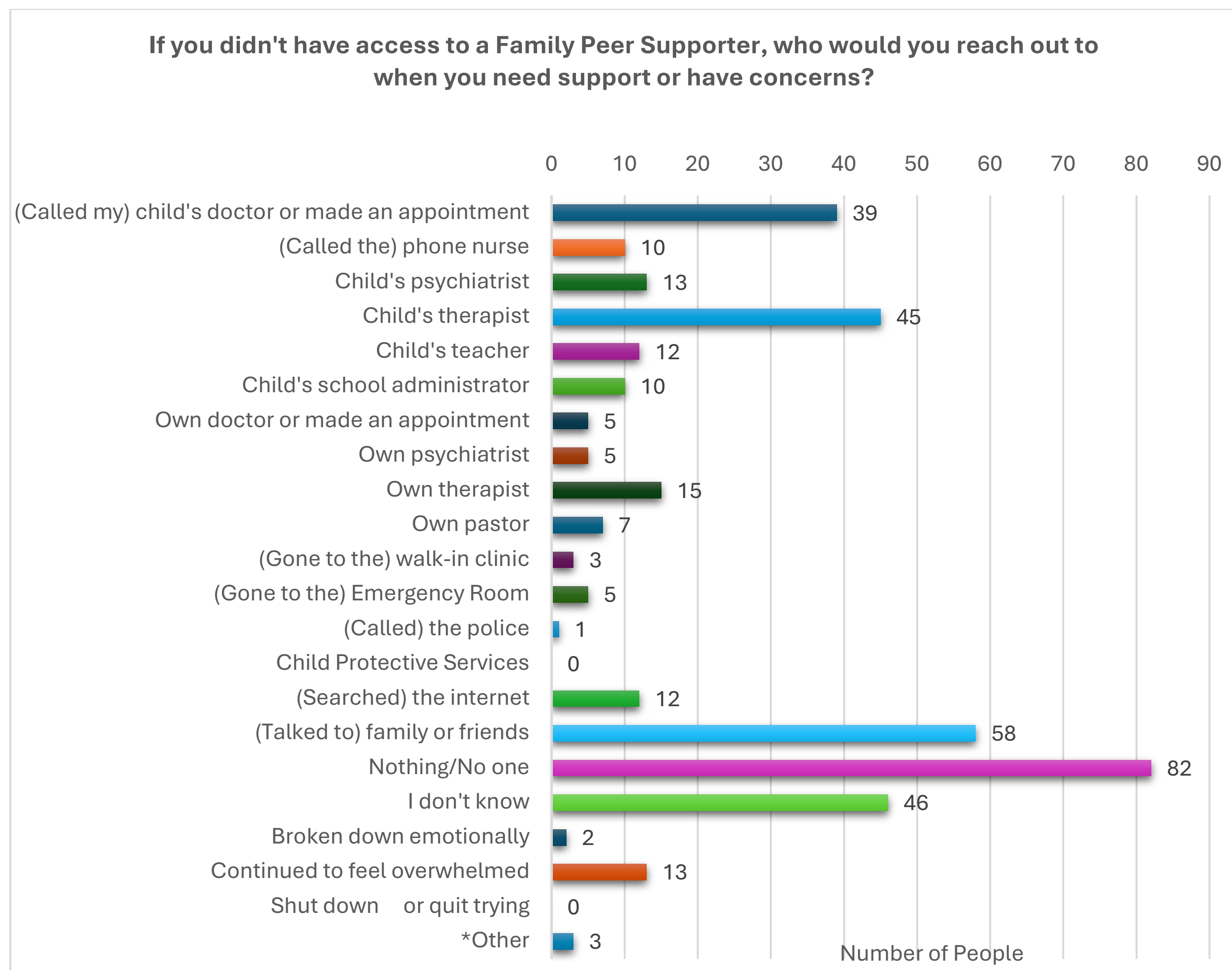
Families were required to sign a Release of Information and Consent to Participate form which allowed the Family Peer Supporter to communicate with the clinic or provider they were working with, document the interactions with the families, and enter data on the families into a statewide database known as CHRIS. The forms were uploaded to the database and kept with the family's record to confirm compliance. The family's information including demographics, contact information, and encounter notes were documented. Family Peer Supporters used DAP Notes for documentation. DAP stands for Data, Assessment, and Plan. Family Peer Supporters kept their DAP notes in a secure, double password protected file program on their laptops. Information regarding the encounter that was entered into the statewide database was generalized and less specific to comply with HIPAA. Data pertaining specifically to the child was entered into the child's Electronic Health Record. Encounters with families without signed consents were tracked separately. Usually, 2-3 attempts were made to get the consent form signed and returned before Family Peer Support services would end.

Data Collection

The purpose was to collect data from the families who utilized our Family Peer Support services to show the need for and value of Family Peer Support. Data was also used to develop and grow the Family Peer Support profession and workforce and build sustainable funding. Time spent providing 1-on-1 support to the families, researching, and documenting was tracked in the

statewide database CHRIS, later changed to REDCap. This data was used to evaluate time spent providing direct services, to track the number of families served, and in quarterly reports to the funder.

As discussed earlier in the Outcomes section, families were also surveyed, and that data was used to show the value of Family Peer Support and the positive impact on families. Family Peer Support was shown to benefit the providers and healthcare system by reducing costs. The graph below shows how families answered the survey question, "If you didn't have access to a Family Peer Supporter, who would you reach out to when you need support or have concerns?" Often parents and caregivers utilize higher levels of care not because it is needed but because other, more appropriate support is not available. Family Peer Supporters provide support beyond the typical 9-5 workday which can reduce the use of police and emergency rooms for non-crisis events, saving time and money.



The cost of a Family Peer Supporter is $21 per hour. This cost is significantly lower than the alternative support services families said they would have reached out to had they not had access to a Family Peer Supporter. A visit with the child's doctor costs $277, the phone nurse $94.50, the child's psychiatrist $97, and the child's therapist $160. Support services for the parent such as their doctor, psychiatrist, and therapist have similar costs as the child's. Same day care and emergency services are even higher with a walk-in clinic visit costing $112.50, an emergency room visit $1233, and police dispatched to the home $165.

This data was used to calculate the return on investment of Family Peer Support services which was presented to Montana's Department of Public Health and Human Services, Legislators, and the Governor resulting in $700,000 allocated to Family Peer Support in behavioral health settings. A Legislative Committee Bill for creating Family Peer Support state certification is being presented at the next session in part due to data collected from the surveys.

The above graphic shows the financial return on investment of Family Peer Support. As explained earlier, families were surveyed after every interaction and asked who they would have reached out to if a Family Peer Supporter was not available. Each person or service they chose had a cost value associated with it. The costs of these services and utilization frequency were totaled and the cost of a Family Peer Supporter was subtracted to get the total cost savings. The total cost savings was then divided by the number of interactions surveyed to get the savings per Family Peer Support interaction of $151.83. This figure was multiplied by the number of Family Peer Support interactions per year to get the yearly savings of $314,896.57. That figure was divided by the number of Family Peer Supporters working during the demonstration project to get the annual saving per supporter of $125,958.63. 80% of families served had Medicaid which gave us the Medicaid dollars saved per year which when divided by the number of Family Peer Supporters gave us the total Medicaid dollars saved per Family Peer Supporter. For every Family Peer Supporter, MT Medicaid saves $112,103.18 annually.

Services

Family Peer Support services were free to all families. Family Peer Supporters worked 1-on-1 with parents and caregivers raising children with behavioral health challenges and/or special healthcare needs. Referrals came as warm handoffs from providers, formal requests from providers, and emails from outside organizations. Family Peer Supporters spoke with families in-person, over the phone, or by telehealth. The Family Peer Supporter introduced themselves, explained the service, and assured them that all interactions were confidential except as required by mandatory reporting laws. They connected and engaged with the parent or caregiver through sharing their lived experience and actively listening. They helped identify needs and connect the family to resources. Consent forms were either signed in-person or sent via email for electronic signature. Documenting the encounter immediately afterwards was important for accuracy. Family Peer Supporters followed up with families and continued to provide support for as long as the family felt it was needed.

Awareness

Bringing awareness to Family Peer Support across Montana was a priority. Brochures, presentations, networking meetings, podcasts, vendor booths, articles, and a web-based presence were all utilized to educate people about what Family Peer Support is and its value to families.

MPN began hosting a monthly webinar series, Family First Wednesdays, for Family Peer Supporters and families raising children with behavioral health challenges and/or special healthcare needs. Topics focused on local and statewide resources, programs, and services. Parents also share their lived experience navigating holidays, finding summer activities, and building resilience.

System

In Montana, organizations serving children with behavioral health challenges and special healthcare needs and their families are siloed. Information on services is hard to find and navigating the healthcare system is difficult. MPN organized a Networking Social for providers supporting families learn about available programs, connect and work more cohesively. Families with lived experience have been providing support under varying titles, mostly without pay, with undefined job duties, and often without a formal code of ethics. Because of this, it was important to develop professional standards and certification for Family Peer Support in Montana. State and grant funding focuses on programs and services for families. While these are important, without funding for workforce development, statewide networks, and technical assistance,

Family Peer Support in MT will continue to lack sustainability. Services and programs for families will come and go, leaving families with inconsistent or nonexistent support.

Workforce Development

MPN worked with the National Family Support Technical Assistance Center to form and facilitate the Montana Family Peer Support Task Force. The purpose of the Task Force was to identify the needs and develop the fundamental elements necessary to grow and maintain a sustainable Family Peer Support workforce in Montana. The Task Force met for one year and developed a scope of practice, code of ethics, training standards, and certification requirements for Family Peer Support. Family Peer Support certified training is also in the final stages of development at MPN.

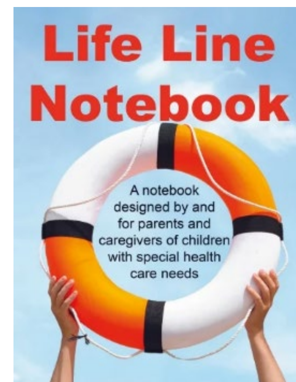
Membership/Statewide Network

Montana's Peer Network offered a free Family Membership which includes a bi-monthly e-newsletter, access to a family Facebook group, and updates on events. Family Membership is intended to build a statewide network of families. Building a statewide network is key for connecting families with similar lived experiences with each other and for increasing advocacy for families, services, and funding.

Family Resources

Being able to give families tangible tools is important. Family Peer Supporters created guidebooks for families and had a lending library. Family Peer Supporters developed training for parents and caregivers accessible through a virtual learning platform. A monthly peer-run support group for families was also established.

The Life Line Notebook



From their own lived experience raising children with special healthcare needs, MPN’s Family Peer Supporters knew how hard it was to keep track of their child’s numerous appointments, providers, clinic locations, tests, medications, and so much more. They knew the frustration of forgetting to ask the provider all the questions they had thought of before the appointment or not being able to remember all the information and instructions they were given during the appointment. With this in mind, the Family Peer Supporters created and published The Life Line Notebook. This invaluable resource is for parents and caregivers to keep track of their child’s needs, appointments, questions for providers, medication, schedule, names and phone numbers of providers, and other necessary information pertaining to their child’s healthcare. There is also an important section on self-care for the parent or caregiver. The Life Line Notebook is available for purchase on MPN’s website at mtpeernetwork.org/store/.

Case Studies

Case Study #1

The parent was referred to the Family Peer Supporter by the provider after several missed appointments for their son. The provider was concerned about the child’s health condition worsening without follow up visits. The provider had tried to contact the parent several times with no luck. The Family Peer Supporter reached out to the parent and left a voicemail introducing themselves and the types of support they could offer. After not receiving a return call for several days, the Family Peer Supporter called again, this time speaking directly to the parent. The Family Peer Supporter offered their support and listened to the parent’s situation and concerns. The cost of traveling to the clinic was identified as a barrier. The parent also expressed fatigue caring for their child with complex health needs and difficulty attending appointments while caring for the child’s younger sibling. The Family Peer Supporter validated the parent’s concerns and empathized with their struggles. They agreed to meet at a local child’s museum to visit while the children played. They had a great time connecting and the Family Peer Supporter was able to connect the parent to resources for gas cards. The Family Peer Supporter also agreed to attend the child’s next appointment with the provider to help entertain the younger sibling so the parent could focus and communicate with the provider without getting distracted and overwhelmed. The Family Peer Supporter continued calling the parent and providing emotional support as well as attending the next few appointments to offer support with the younger sibling. The provider was thankful for the Family Peer Supporter and their services as it allowed more consistent medical follow up for the child.

Case Study #2

The Family Peer Supporter received a referral from the provider for services for adoptive parents of a 7-year-old girl with behavioral health challenges. The Family Peer Supporter called and spoke with the adoptive mom for 90 minutes. During the conversation, the mom became emotional sharing about the parents’ frustration getting services for their daughter and the exhaustion they felt caring for her daily needs. The Family Peer Supporter shared their lived experience raising a child with a behavioral health diagnosis and having those same feelings of frustration, exhaustion, and defeat. The Family Peer Supporter also gave hope to the mom that they would walk beside her through this and that help for her daughter was possible. At the time the family began receiving Family Peer Support services, no other services or therapies were in place. The Family Peer Supporter made referrals to psychiatry, in-home support, therapy, and special education as well as followed up on the referrals. The Family Peer Supporter visited the parents at their home to provide emotional support and help fill out the stack of paperwork for a neuro psych exam. As services began, the parents expressed a decrease in stress and increased confidence in their ability to care for their daughter’s needs. During a crisis, the Family Peer Supporter accompanied the family to the Emergency Room and helped them advocate for services for their daughter as well as providing emotional support. The Family Peer Supporter made a follow up call to the parents later that day to check with them and offer continued support.

Case Study #3

The Family Peer Supporter (FPS) received a referral to connect with a parent of a two-month-old still in the NICU. During their first conversation, which lasted nearly 45 minutes, the FPS gained insight into the profound challenges the family was facing. One parent of the child had a history of drug use which tragically resulted in the death of the other parent. This situation created significant barriers regarding custody and involvement with Child Protective Services (CPS). The parent expressed deep gratitude for the FPS's empathetic approach, appreciating that they were met with understanding and validation rather than judgment, excessive paperwork, and long checklists to regain full custody of the child. Through their engagement, the FPS learned that the parent was not only navigating the complexities of hospital rounds and CPS communications but was also managing the care of an older child and facing financial instability, with the threat of job loss looming over them. Although the FPS's lived experiences were somewhat different, they were able to resonate with the parent's emotions, providing validation and practical self-care tips. The Family Peer Supporter acted as an advocate within the provider's office and communicated effectively with the CPS caseworker, walking alongside the parent and empowering them throughout this difficult journey. The FPS conducted regular check-ins, and with each interaction, the family's situation showed improvement, demonstrating the positive impact of consistent support and advocacy.

Case Study #4

A referral came in for the Family Peer Supporter (FPS) to meet in person with a parent who was attending an appointment at the clinic with their newest child. While meeting with the parent, the FPS learned this parent was the primary caregiver while their spouse worked out of town most of the month. The parent cared for four children total, the oldest having behavioral health challenges, and the two middle children having diagnoses of ADHD and Autism. The FPS and the parent were able to connect on very similar lived experiences and build an open line of communication if the parent needed someone to talk to, connect them to resources/referrals to avoid long wait times, and someone to validate how overwhelming life could be at times. The Family Peer Supporter in this situation offered a consistent avenue for the parent to feel heard, which the parent expressed that they were thankful to have someone in their corner who made them feel human and they felt safe to open up to. This resulted in the parent feeling deeply supported and not judged if they did ask for help or support.

Limitations & Obstacles

Systems

During the two-year demonstration project, Family Peer Supporters drew on their own lived experiences to identify systemic challenges and barriers within the support framework. They recognized the necessity of enhancing care for the families they served. Many child and family systems are underfunded. There is often a lack of awareness about available services statewide, resulting in inadequate support and resources for families. Additionally, MPN discovered that poor communication among different agencies can create gaps in care, access, and support. Throughout the project, MPN conducted outreach to organizations, clinics, and therapy centers that provide services to families to foster open communication and build a community where families felt empowered to advocate for their children's needs. One agency stated they only hired bachelor's degree or higher, but that they would be open to hiring any qualified family peer supporter. We explained to them this was a barrier because in most cases a parent who is raising a child with special healthcare needs is unable to attain a college degree because their child requires full time attention. The agency didn't seem to understand the challenge.

Another obstacle was duplication of services. Often in healthcare there are roles that overlap or duplicate one another such as case managers, care coordinators, behavioral health tech, and other titles that become a catch all type of role. There is a lack of understanding in the systems the uniqueness of the peer role. A family peer supporter understands what the family in need is going through because they themselves have a lived experience raising their own child with special healthcare needs. These other catch all roles do not. They serve an important piece of

healthcare but lack the personal experience aspect that cannot be learned in a book or with a degree.

Utilization & Bias

MPN also identified that some providers lacked a clear understanding of how to collaborate effectively with Family Peer Supporters. This misunderstanding stemmed from previous experiences with Parent Partners, who primarily served as a resource line. While Family Peer Supporters provided similar support, their main objective was to connect with families and help them navigate their challenges, ultimately fostering resilience among parents and caregivers. A critical aspect of the Family Peer Support role was addressing the assumptions made about the families they supported. Providers often held preconceived notions about a family's situation based on background, which led to inappropriate or inadequate support. This imbalance created distrust, making families hesitant to engage with providers or accept help. To counter these challenges, Family Peer Supporters consistently devised innovative strategies aimed at creating a supportive environment where families could thrive.

Contract Delays

Montana’s Peer Network encountered a significant challenge with the contract once awarded. The initial contract was 2 months delayed starting in December and not October. The grant was for 2 consecutive 1 year contracts (October 1, 2022 through September 30, 2023 and October 1, 2023 through September 30, 2024. Although the contract stated that reimbursements would be processed monthly, the first payment on the October 2022 contract was not made until February 2023. With the second payment delayed until May 2023. This put financial strain on the project from the start. Year two contract was also delayed and took considerable advocacy by the staff and board with both state employees and legislative representatives. While these efforts ultimately proved effective, MPN was compelled to pause services temporarily and inform the families they were supporting. After reaching out to the families to explain the situation, MPN soon received the written contract, allowing services to resume promptly. This experience underscores the ineffective system which interrupts services to families and project continuity.

State data collection system

Part way through the demonstration project, Children’s Special Health Services (CSHS) department at Montana’s Department of Public Health and Human Services changed their data tracking system from CHRIS to REDCap. According to the Family Peer Supporters, the new system was easy to learn. During the transition, Family Peer Supporters were unable to enter data, creating a back log of documentation. In the transition, not all the information moved over, and some of the family data was incorrect. MPN was unable to draw the same information from reports as we had with CHRIS making it cumbersome to continue tracking the same data. No efforts were made to correct the incorrect information in families’ files. It was never clear to

MPN the purpose of the state's data collection system. The information collected was not utilized for analysis to improve outcomes for families or identify underserved populations.

Clinic Sites

It was apparent early in the demonstration project that locations were not fully utilizing their Family Peer Supporter. Some providers were unsure how to introduce the new service to patients' families. Not all families that could benefit from Family Peer Support were referred to the Family Peer Supporter. Family Peer Supporters were asked to deliver services that were more appropriate for case management or care coordination or for families that did not meet the criteria. To overcome this challenge a flow chart was designed and distributed to help providers know which families to refer to MPN. We also developed a video based training for providers to better explain the purpose. Family Peer Supporters were not well integrated into the clinical team. Since the Family Peer Supporters worked for MPN at the locations, they often were not included in team meetings. High turnover rates at clinic sites impeded the development on site of Family Peer Support.

CSHS

Children's Special Health Services (CSHS) within Montana's Department of Public Health and Human Services (DPHHS) did not work very well with MPN for the duration of this project. The bigger picture of this demonstration project was to develop the Family Peer Support workforce and secure sustainable funding statewide, while providing family support. Within DPHHS there is a clear division between CSHS and the Children's Bureau despite both divisions being part of the larger whole of DPHHS. They do not communicate effectively and remain siloed in operations, planning and funding. The focus of CSHS from our initial meeting until our last was spending down the grant funding not on service outcomes or on workforce development for the long term support of families. We experienced minimal commitment to the project despite CSHS being the funder of the project. During our monthly meetings, CSHS staff did not ask questions about the families served, the ins and outs of the project, the Family Peer Supporters effectiveness, or the clinic sites and integration. Information we requested was withheld for months before being provided. The other challenge was CSHS staff turnover. We had three program officers during the project.

Transitioning FPS to Clinics

One of our aims at the end of the project was to have the clinics hire the MPN Family Peer Supporters fully integrating them into the clinic setting. Becoming a clinic employee would allow for further development of the workforce and integration that cannot be achieved through outside contracting. Unfortunately, this did not happen in any of the sites. MPN retained the Family Peer Support staff when the project concluded, transitioning them into other roles in the organization.

One of the reasons we felt clinics refused to hire Family Peer Supporters was because the service had been offered for free from MPN and the previous contractor the Hali Project in total for more than 7 years. The second reason that contributed was the inability for the clinic to bill for the service. Provider agencies tend to not think outside the box when it comes to revenue streams. They get comfortable billing the state of Montana and often overlook funding from grants to supplement services.

Family Peer Supporters

There are limitations and obstacles to employing peer supporters. To be effective supporting someone else one has to be healthy emotionally, have good communication skills and be able to "go to work" on a regular basis. Raising a child with special healthcare needs requires a lot of time and energy which can drain a family peer supporter when it comes to the job itself. Time away from work, whether its planned or unplanned, can interrupt support to families and program development. MPN provides regular training, clinical supervision and coaching, but these may not be enough when a FPS is not healthy emotionally. Not every family member who raises a child with special healthcare needs makes a good family peer supporter. At MPN we have set the bar high for the quality of our work and we have found with both behavioral health and family peer supporters some individuals are unable to rise to those expectations. Not everyone is willing to change and grow as expected at MPN. At heart we are a recovery organization and that requires a personal and workplace commitment to growth.

Key strategies to overcome limitations included:

- **Training and Education**: Offering ongoing training for both Family Peer Supporters and providers focused on cultural competency and collaborative practices.
- **Advocacy**: Ensuring that families' voices are heard and respected within the system.
- **Building Relationships**: Strengthening partnerships between Family Peer Supporters and systems of care to enhance understanding and collaboration and emphasizing the importance of workforce development.
- **Community Engagement**: Actively involving families in the design of services to address systemic issues and biases.

Through these efforts, MPN aimed to create a more inclusive and supportive environment for families and a state-recognized profession for Family Peer Supporters, ultimately improving families' access to care and support.

Conclusion

During this 2-year Family Peer Support demonstration project, MPN was able to build a Family Peer Support model, increase funding for Family Peer Support, and begin the process for state certification for Family Peer Supporters. Overall, MPN met the goals of this project:

1. **Deliver individual, group, in-person, and virtual Family Peer Support services throughout Montana.**
   Family Peer Supporters provided support to 268 families. Most support was provided individually via phone calls to accommodate busy family schedules and Montana's vast geographic area. Another organization was contracted to provide group peer support which MPN promoted by listing group meeting information on MPN's website.

2. **Develop a statewide network of Family Peer Supporters, family-led organizations, families, and other stakeholders.**
   At the end of the demonstration project, MPN had 55 family members in its network. MPN also developed relationships and made contact with organizations and programs serving children with special healthcare needs and their families across the state. MPN also had numerous conversations and meetings with Division Administrators and Bureau Chiefs in MT's Department of Public Health & Human Services as well as state legislators, the Children, Families, Health & Human Services Interim Committee, and HB872 Commission to discuss certification and funding.

3. **Develop and provide standardized training for Family Peer Supporters.**
   Although the curriculum for Family Peer Support certified training is still being developed, training standards were created by the Family Peer Support Task Force. MPN's Family Peer Support certified training will be available January 2024.

4. **Lead the efforts for the sustainability of the Family Peer Support workforce in Montana, including training, funding, and service delivery.** MPN continues to lead the efforts in the development and professionalization of the Family Peer Support workforce in Montana. Family Peer Support certification training and virtual training in leadership skills and professional development will begin in 2025. MPN will take the Family Peer Support model developed through this project, along with the Family Peer Support Toolkit created by the Task Force, and provide support, training, and consultation to organizations and providers implementing Family Peer Support services. A bill for Family Peer Support Certification is being introduced as a Committee Bill in the 2025 Legislative Session. The HB872 Commission included in their recommendations for Medicaid reimbursement for Family Peer Support, which was signed by Montana's Governor. Funding options through federal block grants, Medicaid waivers, and state dollars have been discussed with multiple division leaders throughout Montana's Department of Public Health and Human Services. Available funding for Family Peer Support services grew from $189,000 at the beginning of the demonstration project to $940,000 by the end as a direct result of this demonstration project.

> In June 2024, MT's Governor announced an investment of $700,000 to expand Family Peer Support services for Montana families and caregivers. "Parents and caregivers raising children with behavioral health challenges often neglect their own mental and physical health," Gov. Gianforte said. "To address this important need, our latest investment will improve Montana families' access to services and ensure caregivers are getting the support they need."

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