

“I’ve Been There”

How Connecticut Can Expand Family
and Youth Peer Support Services

2026





Child Health and Development Institute

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This report is dedicated to **Beresford Wilson** whose leadership, vision, and commitment elevated the voice of families with lived expertise throughout Connecticut's behavioral health system for children.

“I’ve Been There”

How Connecticut Can Expand Family and Youth Peer Support Services



EXECUTIVE SUMMARY

In November 2023, *Strengthening the Behavioral Health Workforce for Children, Youth, and Families: A Strategic Plan for Connecticut* was published.* The Plan included eight recommendations to address the behavioral health workforce shortage, including a recommendation to *Expand the youth and family peer support workforce*.

Family and youth peer support services are a well-established component of children’s behavioral health services in many states. They can serve as credible messengers, strengthen engagement in treatment, and improve outcomes for children with behavioral health concerns. While there is a strong family peer support specialist infrastructure within Connecticut, implementation is limited. There is an opportunity to expand the roles of family and youth peer support specialists more systematically.



ABOUT THE REPORT

The Department of Children and Families (DCF) funded the Child Health and Development Institute (CHDI) to work in collaboration with the Children’s Behavioral Health Plan Implementation Advisory Board (CBHPIAB) to identify specific recommendations for expanding youth and family peer support within children’s behavioral health services.

Of note, these recommendations are intended for those services within the child behavioral health continuum. In Connecticut, services for children (under 18) are within the purview of DCF, while the adult system is under the purview of the Department of Mental Health and Addiction Services (DMHAS).

DEFINITIONS USED IN THIS REPORT



Family Peer Support Specialists are parents and caregivers with lived experience navigating behavioral health and related systems who are trained to support other parents and caregivers.



Youth Peer Support Specialists are young adults (typically ages 18-29) with personal lived experience receiving behavioral health services or related system interventions as children or youth who are trained as young adults to support youth.

The report addresses the following project questions:

- 1 What does research indicate about the effectiveness of family and youth peer support services for children with behavioral health concerns?
- 2 What are best practices in regard to roles of family and youth peer support specialists for children with behavioral health concerns?
- 3 What are best practices for training and certification of family and youth peer support specialists?
- 4 What are best practices for implementing family and youth peer support services?
- 5 What are best practices for funding and sustaining family and youth peer support services?
- 6 What is the current landscape of family and youth peer support services within Connecticut and how does it compare to identified best practices?
- 7 What are the potential system-level benefits of expanding family and youth peer support services?
- 8 How can lived experience be expanded throughout the children’s behavioral health system (e.g., within program design, policy development, quality improvement, etc., in addition to the employment of peer support specialists)?

“You are a mom...and someone says, ‘You know what, I’ve been there. Let me help you.’”

– CONNECTICUT PARENT

*The Workforce Plan was funded by the Connecticut Department of Children and Families (DCF) and published by the Child Health and Development Institute (CHDI) in collaboration with the Children’s Behavioral Health Plan Implementation Advisory Board.

METHODS

The project benefited from the guidance of a *Steering Committee* whose members included family peer support specialists, family advocacy organizations, children's behavioral health providers, and DCF. Methods to develop the report included an extensive literature review to identify best practices, interviews with in- and out-of-state experts, focus groups with providers and family members, and surveys of non-clinical* behavioral health staff and youth with behavioral health system experience.

FINDINGS

National Findings

- Common outcomes of family and youth peer support include improved engagement in services and completion of treatment, strengthened social connectedness, emotional well-being, and resilience.
- Roles of family and youth peer support specialists sometimes overlap with those of other non-clinical staff (especially regarding system navigation and care referrals); however, specific activities are often different. Peer support work is anchored in shared lived experience, strategic sharing of personal story, and emotional support that offers a unique approach and benefit distinct from other positions.
- National organizations offer clear guidance and best practices regarding family and youth peer support core competencies and certification models with which some Connecticut family and youth programs are already aligned.
- Organizational readiness, role clarification, and effective supervision are critical to successful implementation of family and youth peer support services.
- Medicaid reimbursement is common in other states, and blended funding sources are best to sustain family and youth peer support services.

Connecticut Findings

- Connecticut has a strong infrastructure upon which to build as well as opportunities to strengthen service implementation.
- Connecticut currently offers training and certification models for family and youth peer support services that are consistent with national best practices.
- Families who have had experience with peer support in the state report positive and beneficial experiences for themselves and their children.
- Very few youth-specific peer roles, or training or certification opportunities exist statewide.
- Family peer roles are not systematically implemented and serve only a small fraction of families who could potentially benefit from peer services.
- Peer support services have the potential to offer benefits as prevention and early intervention strategies.
- Roles and responsibilities vary across programs, but generally demonstrate consistency with best practices. There is sometimes overlap with other non-clinical positions and an opportunity for more clarity.
- Peers lack a clear career ladder/advancement opportunities.
- Training and supervision structures vary widely across programs.
- Funding remains grant-dependent and vulnerable to disruption.

RECOMMENDATIONS

- 1 Secure public and private insurance coverage of services provided by peer support specialists.
- 2 Expand access to existing family and youth training and certification programs.
- 3 Strengthen behavioral health programs' readiness and capacity to integrate peer support services.
- 4 Prioritize identified behavioral health services and family and youth needs as funding becomes available to expand the peer support workforce.
- 5 Implement peer support services as prevention and early intervention strategies.
- 6 Expand the role of individuals with lived expertise throughout the children's behavioral health system.
- 7 Evaluate peer support services and track outcomes to support sustainability and inform gaps in research.

*Throughout the document, the term "clinical" and "non-clinical" are used to distinguish categories of staff and roles within a behavioral health team. Clinical roles (e.g., providing diagnosis, therapeutic intervention, etc.) typically require graduate-level education and often a license (e.g., psychologist, Master-level social worker, marriage and family therapist, etc.). Non-clinical roles (e.g., supporting system navigation, providing psychoeducation, etc.) typically do not require graduate-level education, or may not have any educational requirements, but may require specific training and certification (e.g., peer support specialist, care coordinator, etc.).

Introduction

Connecticut's Behavioral Health Services for Children and Families

Connecticut has an established reputation for its comprehensive array of behavioral health services and implementation of evidence-based treatments for children. For many years, however, the system has been challenged by a significant shortage of the clinical workforce and limited lived expertise within the system, with simultaneously increasing demand for services. In November 2023, [*Strengthening the Behavioral Health Workforce for Children, Youth, and Families: A Strategic Plan for Connecticut*](#) (Workforce Plan) was published to identify solutions regarding escalating challenges with the pipeline, recruitment, retention and diversity of the children's behavioral health workforce. The Workforce Plan was funded by the Connecticut Department of Children and Families (DCF) and was published by the Child Health and Development Institute (CHDI), in partnership with the Children's Behavioral Health Plan Implementation Advisory Board (CBHPIAB).

One of the Workforce Plan's eight recommendations was to [*Expand the youth and family peer support workforce*](#), beginning with development of an implementation plan for scaling up family and youth peer support. The employment of peer support specialists is less common in children's behavioral health services in Connecticut, compared to many other states, despite being consistent with the [*System of Care*](#) approach and values (see text box).¹ Family and Youth Peer Support Specialists can serve as credible mentors, advocates, and navigators. They are individuals with lived experience navigating behavioral health systems (either for themselves or their child) and offer services to caregivers or youth that are not only grounded in mutuality and empathy, but where the sharing of experiences *is itself* a service.

The CBHPIAB, per its legislatively mandated role to guide implementation of the [*Children's Behavioral Health Plan for Connecticut*](#) (see next page), as well as its interest in implementing the recommendations from the Workforce Plan, identified expanding the youth and family peer support workforce as one of its priorities for FY 2025.

In response, DCF funded the Child Health and Development Institute (CHDI) to work in collaboration with the CBHPIAB to identify specific recommendations for expanding youth and family peer support within children's behavioral health services. This report offers recommendations and associated action steps for the State of Connecticut to expand the roles of family and youth peer support services within the children's behavioral health system.

THE SYSTEM OF CARE APPROACH

The **System of Care** approach was first introduced in the 1980s to address challenges and gaps in serving children with mental health needs. The approach offers a comprehensive continuum of services to address varying needs, coordination across systems, and services to be delivered in the **least restrictive** environment possible, and in partnership with youth and families.

System of Care core values for service delivery are:

- Family- and youth-driven
- Community-based
- Culturally and linguistically-appropriate

Peer support has been identified as a core component of the comprehensive service array.

Most states, including Connecticut, have adopted the System of Care approach to children's behavioral health.



CHILDREN'S BEHAVIORAL HEALTH PLAN

The [Children's Behavioral Health Plan](#) was developed in response to the Newtown tragedy. It was enacted in 2014 by the Connecticut General Assembly as a blueprint to guide improvements of the state's behavioral health system for children. The Plan reflects a comprehensive process to collect input from families, providers and other stakeholders throughout the state.

The plan continues to provide a blueprint for the state's system development, with the [Children's Behavioral Health Plan Implementation Advisory Board](#) serving as the guiding body in its implementation.

Report Focus and Definitions

Peer support specialists are increasingly recognized as valuable members of the behavioral health workforce (with over 100,000 certified nationwide²). While peer support is most commonly associated with the adult substance use recovery and mental health systems, youth and family peer support specialists have increasingly been included as members of the children's behavioral health workforce in the United States. The services provided by peer support specialists vary considerably, resulting in frequent confusion about peer roles. Services may range from informal volunteer services, such as those provided among peers within a recovery or support group, to a formal certified peer support specialist embedded as an employee within a behavioral health agency.

There can be great value to children and families across this full range of peer support services, however to narrow the focus of recommendations, this report is specific to:

- Paid staff positions for peer support specialists.
- Roles requiring formal training of peer support specialists *in addition* to their lived expertise.
- Peer workforce roles specifically supporting children who have or who are at risk for behavioral health concerns and their families.

Note that for the purposes of this report "behavioral health" refers to mental health and/or substance use.





The following definitions of family peer support and youth peer support are used throughout the report and have been informed by national best practices as well as current Connecticut-based peer programs.

Family Peer Support Specialists are parents and caregivers with lived experience navigating behavioral health and related systems who are trained to support other parents and caregivers.

Youth Peer Support Specialists are young adults (typically 18–29) with personal lived experience receiving behavioral health services or related system interventions as children or youth who are trained as young adults to support youth.

Project Questions

The following questions are addressed in the report to provide the state with the information needed for decisions regarding funding, design, and implementation of family and youth peer support services.

- 1 What does research indicate about the *effectiveness* of family and youth peer support services for children with behavioral health concerns?
- 2 What are best practices regarding the *roles* of family and youth peer support specialists for children with behavioral health concerns?
- 3 What are best practices for *training and certification* of family and youth peer support specialists?
- 4 What are best practices for *implementing* family and youth peer support services?
- 5 What are best practices for *funding and sustaining* family and youth peer support services?
- 6 What is the *current landscape* of family and youth peer support services within Connecticut and how does it compare to identified best practices?
- 7 What are the potential *system-level benefits* of expanding family and youth peer support services?
- 8 How can *lived experience* be expanded throughout the children's behavioral health system (e.g., within program design, policy development, quality improvement, etc., in addition to the employment of peer support specialists)?

METHODOLOGY

The project benefited from the guidance of a **Project Steering Committee** whose members included family peer support specialists, family advocacy organizations, children's behavioral health providers, and DCF. A full list of **Project Steering Committee** members is included on [page 4](#), and a list of key informants and contributors is included on [page 5](#). These individuals provided guidance on the design of the project as well as draft findings and recommendations. In-kind support was also provided through the SAMHSA³ Program to Advance Recovery Knowledge (SPARK) national training and technical assistance center. This assistance offered an important national perspective as well as connections to other states with more extensive experience with peer support.

To understand the current landscape of family and youth peer support in Connecticut and address the identified project questions, multiple data sources were employed. Data collection occurred between September 2024 and July 2025 and included a literature review, semi-structured interviews, focus groups, and surveys.

Literature Review

The literature review drew on four distinct categories of sources: **(1)** peer-reviewed research and select grey literature containing evaluation data were used to summarize the evidence on peer support roles, training, certification, supervision, integration, and workforce challenges; **(2)** state certification and training materials were used to summarize common and best practices across states; **(3)** toolkits and technical assistance resources were reviewed as adaptable implementation guides rather than evidence of effectiveness; and **(4)** federal guidance was reviewed both for research-informed best practice recommendations and for policy or funding frameworks relevant to workforce development.

Peer-reviewed sources were identified through targeted searches in PubMed, PsychINFO, and Google Scholar using combinations of terms such as **youth peer support, family/parent/caregiver peer support, young adult and transition-aged youth, lived experience workforce, peer support specialist** (and related items, including **recovery support specialist**), **training and certification, integration, supervision, and behavioral health**. Studies published between 1998 and 2025 were included if they examined the roles, implementation, outcomes, or best practices for youth and/or family peer support in behavioral health or closely related systems (e.g., child welfare, education, juvenile justice). Both quantitative and qualitative, as well as systematic and scoping reviews, were considered.

Interviews

Semi-structured interviews were conducted with peer workforce leaders, certification experts, and policy stakeholders from Connecticut and four additional states (Massachusetts, Ohio, Tennessee, and Georgia). The full list of individuals interviewed is available on [page 5](#).

Interviews explored peer role definitions, certification structures, supervision practices, funding mechanisms (including Medicaid billing), and state-level implementation strategies. Interview notes were thematically analyzed and interpreted alongside focus group and survey data to identify common challenges, strengths, and models of success.

Focus Groups

Six virtual focus groups were conducted between March and June 2025, including three with parents/caregivers of children with behavioral health concerns, and two with behavioral health providers. One additional focus group consisted of a combination of Connecticut youth (under age 18) as well as parents/caregivers. In total, there were 13 parents/caregivers, 15 providers, and 2 youth included across focus groups. The participation by so few youth, despite varied recruitment efforts, may reflect broader system-level challenges with youth engagement. Groups explored experiences with peer support services,

³ Substance Abuse and Mental Health Services Administration

perspectives on role clarity, supervision, and workforce integration, as well as recommendations for statewide system improvements. All groups followed a semi-structured discussion guide and were facilitated by CHDI staff via Zoom. Detailed notes and transcripts were reviewed collaboratively and analyzed thematically.

Caregiver participants represented a range of lived and professional experiences, including caregiving for youth with complex behavioral health needs, navigating special education and DCF involvement, and in some cases, working as family peer support providers themselves. Focus groups were inclusive of family members who had received peer support services as well as those who had not.

Provider participants held diverse roles within Connecticut's children's behavioral health services, including care coordination, clinical supervision, family liaison, and program administration. Several also identified as having lived experience as caregivers or former peer staff. Focus groups were inclusive of providers who had experience working with peer support specialists and those who had no direct experience with peer support.

The two youth participants were ages 15 and 16. Both had prior and/or ongoing experience with peer support services as well as a mix of experience with varying child-serving systems within the state.



Surveys

To better understand the perspectives of non-clinical behavioral health staff working with youth and families, an online survey was conducted in Spring 2025. The survey gathered information on workforce roles, supervision, service settings, access to training and certification, peer support integration, and workforce challenges. It was disseminated through provider networks and stakeholder organizations and encouraged broad sharing across Connecticut's child behavioral health system. A copy of the survey questions is included in [Appendix A](#).

A total of 75 staff responded, representing a wide range of roles. These included peer specialists (comprised of 11 family peer support specialists and 5 youth peer support specialists), other non-clinical roles (73%) such as care coordinators, case managers, community health workers (CHWs), and administrative or navigation staff, and clinical roles (5%) in therapeutic or counseling positions. Both peer and non-peer positions were included to distinguish the roles and experiences of peers from those of other non-clinical behavioral health staff. Respondents worked across diverse settings, including home-based services, outpatient clinics, mobile crisis, and school-based programs, and reported serving children, adolescents, transition-aged youth, and caregivers.

A separate survey of youth was conducted. It was a brief, anonymous survey intended to elevate the perspectives of young people with lived experience with the behavioral health system. Eligible respondents were between the ages of 16 and 28 and had received services within the past five years. The survey included a mix of multiple choice and open-ended questions focused on service access, experiences with youth peer support, and recommendations for improvement.

The survey was distributed through provider and advocacy networks, including Youth MOVE National, CT Support Group, and a statewide young adult Discord platform. Fourteen youth responded, with nine completing the full survey and five submitting partial responses. Five participants reported working with a youth peer support provider, most commonly in outpatient or in-home settings. Given the limited number of responses, survey results may not generalize to youth more broadly. Therefore, findings in the report that are specific to the results of the youth survey are identified as such.



FINDINGS

1

What does research indicate about the effectiveness of family and youth peer support services for children with behavioral health concerns?

How are behavioral health treatment outcomes enhanced for families and children?

How can peer support services be engaged to support prevention or early intervention?

What family or youth needs can most benefit from peer support services?

Research on family and youth peer support services is increasing and there is strong evidence regarding the beneficial outcomes for children and families. The following section summarizes the demonstrated benefits to both families and children, as well as the specific needs that are best supported through peer support services. Limitations and current gaps in the research, including few randomized control trials (RCTs), lack of reporting of effect sizes, and the wide variation in peer roles and program types, are also discussed.

Family and Youth Benefits

There is a growing body of evidence that highlights peer support's positive impact on families, which includes families' engagement in services and overall family functioning.³ Research suggests that parents receiving family peer support are more likely to remain actively involved in their child's treatment, ensuring greater service continuity and adherence to recommended interventions.^{3,4,5} Additionally, these services promote stronger collaboration between families and treatment professionals. Families who receive training and guidance from peer support providers report an increased sense of partnership with professionals, leading to more family-centered care, improved communication, and shared decision-making.³

Research on peer support commonly addresses services within higher levels of care (e.g., psychiatric or substance use inpatient services) and crisis services (e.g., emergency department use or mobile crisis interventions). In acute settings like psychiatric emergency rooms or inpatient units, peers serve as bridges in moments of crisis, offering comfort, planning, and connection to aftercare. A youth peer might sit with a child while they await an evaluation, or a family peer might speak with parents to normalize the experience and clarify next steps.



“[Peer staff] helped me navigate the system, supported me, educated me, and empowered me. There’s still so little support for parents and caregivers. [The family agency] gave me – and so many parents – hope.”

- CONNECTICUT PARENT

“They bring immediate grounding when everything is chaotic. Sometimes just being in the room changes the dynamic.”

**- CONNECTICUT PROVIDER REGARDING
PEER SUPPORT WITHIN CRISIS SERVICES**

Peer support has been found to be effective in lower levels of care as well (e.g., outpatient services or Wraparound care coordination). In outpatient clinics (e.g., weekly therapy or pediatric consults), peers typically offer emotional support before or after sessions, help caregivers organize questions, and connect families with community-based services. The relationship may be one-on-one or in small groups. One caregiver in a focus group shared that, while receiving Wraparound care coordination, a peer helped develop and practice de-escalation strategies at home, created a safety plan, and helped secure tangible support like summer camp and transportation.

While peer support services can be a **component** of a behavioral health treatment plan, they may also be offered independently as a prevention or early intervention strategy.⁶ Research for this approach to peer support tends to be more concentrated in less formal peer support services (e.g., volunteer services, support groups, etc.).⁷ This research is more limited, but still promising, and may be especially important for youth experiencing needs with low acuity and/or youth identified as at risk (e.g., youth experiencing homelessness, or involvement with juvenile justice or child welfare who do not necessarily have a behavioral health diagnosis). In prevention-focused roles, youth peers may deliver workshops, run peer groups, or speak on school panels to de-stigmatize mental health, whereas family peers may partner with parent-teacher organizations or school teams, helping parents prepare for Individualized Education Plan (IEP) meetings or disciplinary conferences.

Family peer support and youth peer support are each associated with unique strengths and outcomes within the research. Research specific to each type of peer support is summarized below.

PEER SUPPORT IN PRACTICE: NEW YORK STATE

Findings from an evaluation of caregiver and youth satisfaction of mental health services provided by the State of New York found that both caregivers and youth who were able to access a peer advocate were more likely to be satisfied with the mental health services received. Note that the State of New York includes “access to a peer advocate” as a question on their satisfaction survey. Caregivers and youth reported higher ratings on the Youth/Family Assessment of Care Satisfaction Survey, reflecting key aspects of care engagement, such as getting services that were helpful, being able to get services when needed, and being included as a partner in planning their services. Caregivers further reported improved social connectedness, and youth reported having a better understanding of psychotropic medication choices.¹⁹



Family Peer Support

One of the most well-documented benefits of family peer support is reduction of stress and anxiety among caregivers. Caregivers' ability to connect with another parent regarding a shared experience offers them reassurance, emotional validation, and practical coping strategies that lessen anxiety around meeting their child's needs.^{3,8,9} Peer support can reduce caregiver isolation and promote resilience. In a study of a peer-led caregiver support group, outcomes of sharing experiences, exchanging strategies, and finding validation in a nonjudgmental space included sustained engagement in services and improved long-term resilience within families.¹⁰ Caregivers receiving family peer support gain the confidence and skills needed to navigate complex behavioral health systems, actively participate in treatment, and advocate for their children across systems.¹¹

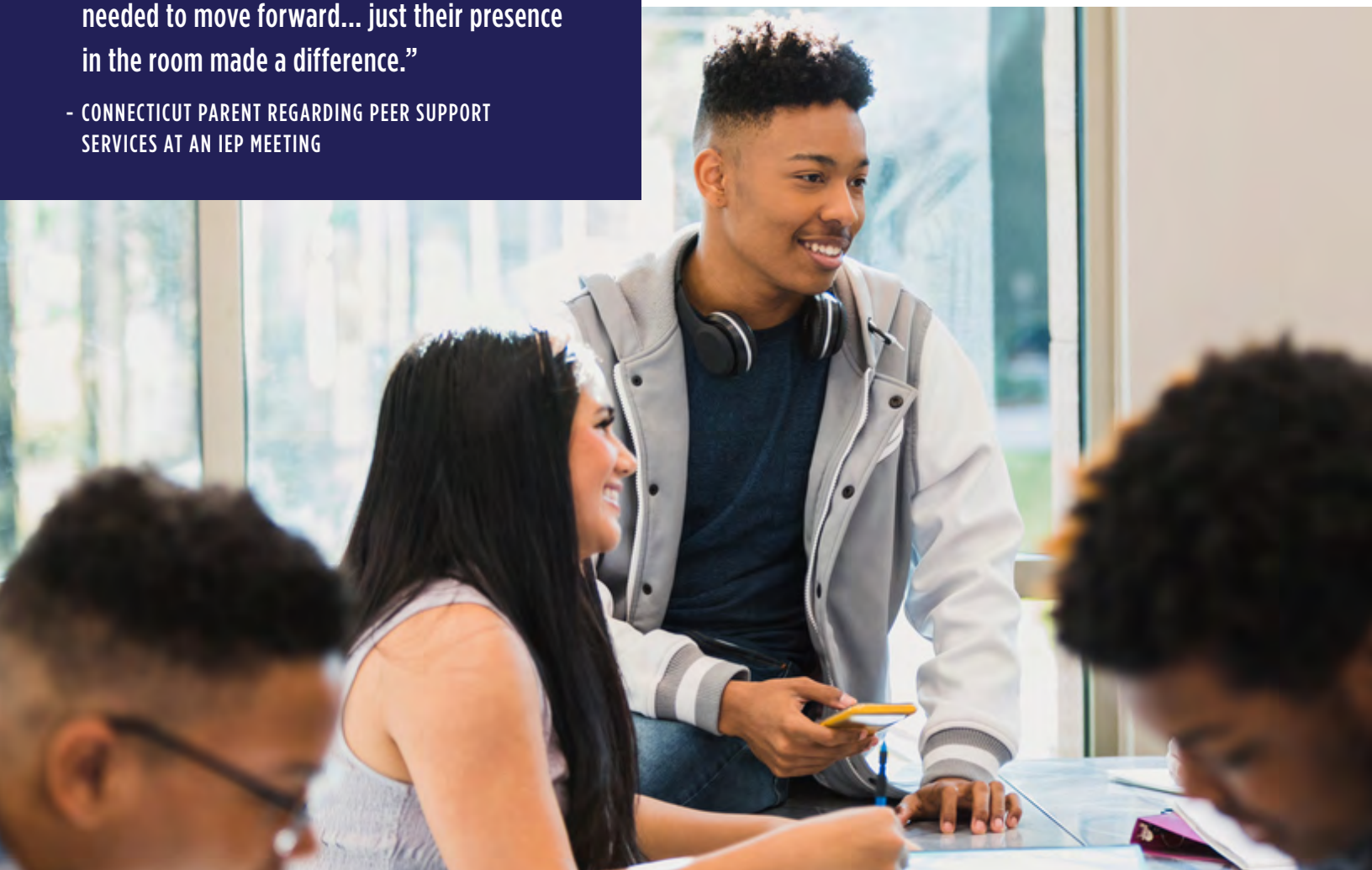
"They helped him get the accommodations he needed to move forward... just their presence in the room made a difference."

- CONNECTICUT PARENT REGARDING PEER SUPPORT SERVICES AT AN IEP MEETING

Youth Peer Support

Peer relationships play a critical role during adolescence, coinciding with the peak developmental period for the onset of mental health challenges.¹² Research on the effectiveness of youth peer support for children with or at risk for behavioral health concerns remains limited, however there is indication that youth peer support strengthens engagement in treatment, increases trust in service providers, and reduces stigma experienced from family and/or community.^{13,14,15}

Some youth may experience higher levels of stigma around behavioral health services, which can further discourage help-seeking behavior. Peer support has been demonstrated to serve as a buffer against this stigma by creating trusted relationships that promote mutual understanding and cultural responsiveness.^{16,17} Research suggests that participation in peer support programs is associated with improved social-emotional functioning and decreased family conflict among adolescents receiving mental health services.¹⁸



Specific Needs

The benefits of family peer support extend beyond behavioral health settings and have been documented in other systems such as child welfare and juvenile justice.^{19,20} Peer support can help families with multi-system involvement understand and reframe their experiences, feel less isolated and more socially connected, and debunk stigma and damaging myths regarding mental health.⁵ Outcomes related to populations with cross-system needs include greater compliance with and participation in program requirements by the families, stronger parent-child relationships, and improved reunification among children involved in the child welfare system.^{17, 21}

Outcomes of Peer Support Among Specific Youth Populations

- **Youth identifying as LGBTQ+:** While there is limited research on formal peer support services, engagement with informal peer support networks has been associated with resilience, social connection, and identity affirmation to counteract stigma and discrimination.²²
- **Youth in foster care or transitioning out of foster care:** Enhanced emotional resilience and economic stability, with evidence that it counteracted psychological stress associated with foster care experiences and helped with processing bereavement.^{23,24}
- **Youth experiencing homelessness:** Improved social connectedness, expanded access to mental health services, housing, education and employment opportunities.^{25, 26}
- **Youth who are immigrants or refugees:** Reduced barriers to service utilization, improved trust, reduced isolation and greater mental wellness.²⁷
- **Youth with serious mental illness (SMI) (particularly those historically underserved, such as Black and Latine youth):** Increased engagement in outpatient services.⁹
- **Youth with substance use disorder (SUD):** Increased likelihood to develop positive coping mechanisms, remain in treatment programs, and maintain motivation for recovery; particularly helpful as youth with SUD have a greater distrust of traditional service providers.²⁸

Limitations

Despite the growing evidence base for peer support, several limitations in the research and ongoing structural challenges hinder its full integration into behavioral health systems. One of the most significant research gaps is the lack of rigorous randomized controlled trials and longitudinal studies evaluating peer support's long-term impact. While observational studies and qualitative research suggest strong engagement benefits, there is limited experimental evidence to determine causal relationships between peer support interventions and clinical outcomes.^{29,20} Additionally, effect sizes for peer interventions are not always reported or vary widely across studies, with lower effect sizes typically observed in unstructured peer support models compared to more formalized, structured programs.²⁹

Another challenge in the literature is the inconsistent definition of peer support across studies, making direct comparisons and generalizations difficult.³¹ Peer support programs vary widely in structure, training requirements, and level of integration within behavioral health systems. Some interventions follow highly structured approaches with standardized training and certification, while others emphasize informal, community-driven support.

Finally, there is limited empirical research on how to effectively scale **culturally responsive** peer interventions. Similarly, despite the disproportionate mental health needs among LGBTQ+ youth, research on LGBTQ+-specific peer support remains largely qualitative or anecdotal, with few peer-reviewed studies examining its impact on clinical and behavioral health outcomes.³²

What are best practices in regard to roles of family and youth peer support specialists for children with behavioral health concerns?

What are core roles of family and youth peer support specialists?

How are peer roles different from other non-clinical roles?

Family and Youth Peer Support Specialists serve as credible mentors, advocates, and navigators within the children's behavioral health ecosystem. They are hired precisely *because* they have personally navigated systems such as behavioral health, special education, juvenile justice, or child welfare, either as a youth with lived behavioral health needs or as a caregiver supporting such a youth. **This lived experience is not incidental but central to their role.** It anchors their practice in mutuality, recovery, and personal storytelling, setting them apart from other non-clinical staff such as case managers, care coordinators, or CHWs. Whereas those roles rely primarily on professional training, peer specialists draw on shared identity and recovery journeys, positioning lived expertise as their primary qualification.³³ [Appendix B](#) provides a description of common non-clinical positions within children's behavioral health services.

“You are a mom...and someone says, ‘You know what, I’ve been there. Let me help you.’” – CONNECTICUT PARENT

Differences Between Peer Roles and Other Non-Clinical Roles

While family and youth peer specialists share broad role categories with other non-clinical staff (e.g., engagement, emotional support, and system navigation), their approach and often the specific activities look different in practice. For peers, lived experience is not incidental, but instead central to their role and value. Peers’ strategic storytelling and ethical disclosure of personal experience (which would often be considered inappropriate if shared by other staff) offers an anchor in building engagement and emotional connection and is typically unique to peer roles. Peer specialists use their own wellness and recovery journeys to build trust, validate feelings, and model hope and resilience.^{29, 34}

Peers adopt a non-hierarchical stance, walking alongside children, youth, and families rather than positioning themselves as experts. Peer specialists intentionally minimize power differentials to promote empowerment and equality.²⁷

Beyond individual support, peers also bring lived expertise into program design, training, and policy advocacy. This systems-level function distinguishes peer roles from other non-clinical positions, which typically emphasize individual outcomes rather than organizational or policy reform.



“It’s almost like sitting down with a friend who cares about you...If I get off track, she gets it.”

– CONNECTICUT PARENT

Core Functions Across Peer Roles

The following roles are frequently identified as core to both family and youth peer support in literature and best practice documents. The descriptions below include reference to how the roles may function differently for a family peer as opposed to a youth peer where relevant. Additionally, where there is overlap with other non-clinical roles, the below descriptions provide examples of how the specific activities and approach may differ when provided by a peer.

Engagement and Relationship-Building

Peers build authentic, non-judgmental relationships that reduce stigma and foster trust, especially among families and youth who may be hesitant to engage in services. Shared experiences create a rapport that clinical providers sometimes have challenges replicating.^{24, 27, 35} Peers may engage caregivers and youth through outreach or early service contact, similar to other non-clinical staff, but they build trust and credibility by ethically and strategically sharing their own lived experiences, reducing barriers, and serving as a relatable “bridge” to services.

Emotional Support and Mutuality

Peer relationships are grounded in mutual respect, hope, shared identity, and emotional presence. Peers validate experiences without judgment, helping individuals and families feel seen, heard, and believed. They support individuals in rediscovering identity and purpose beyond diagnoses, cultivating hope, recognizing recovery as nonlinear and deeply personal, and holding space for both progress and setbacks with compassion.³⁶

Family peers may provide one-to-one mentorship to parents and caregivers, use ethical self-disclosure to offer validation and reassurance, and facilitate family support groups or peer-led discussions. Whereas youth peers may connect generationally, focus more on modeling their own recovery and resilience in everyday life, and may teach other youth self-regulation and healthy coping strategies.

Emotional support is also provided by other non-clinical staff, but typically as a by-product of another service (e.g., listening during a screening or referral). **For peers, emotional support itself is often the service** (e.g., a family or youth may call or text a peer “just to talk” and the peer will be available to listen and respond using their lived expertise combined with their formal training on boundary setting, etc. as needed).

System Navigation

Drawing on lived experience across child-serving systems, such as behavioral health, education, juvenile justice, and child welfare, peers act as knowledgeable bridges to services. They demystify complex processes and help families identify and access needed support. Peers may also work collaboratively, in-person with families and youth while they contact and navigate systems.^{37, 38}

Family peers may guide caregivers through complex processes, such as IEPs, planning and placement team (PPT) meetings, eligibility determinations, and developmental service planning, and may accompany them to appointments. Youth peers educate young people about services, rights, and system processes, support transition planning across systems and life stages, and connect youth directly to needed services (e.g., housing, school, recovery programs).

System navigation and care coordination are common across many non-clinical roles, making role clarity essential to avoid duplication. What sets peers apart is their use of personal storytelling to validate the challenges of navigating complex systems or accessing services, and their willingness to walk alongside families and youth – often literally – by attending meetings such as IEPs or court hearings to offer support or guidance.

Advocacy and Empowerment

Peers empower families and youth through information, modeling, and skill building to use their voice, ask questions, and set goals aligned with their values. Peers elevate lived experience in treatment planning as well as in broader decision-making spaces, including program design, policy development, and system transformation efforts.^{6, 8, 39, 28}

Family peers may coach caregivers to self-advocate in school, treatment, and legal settings; prepare them for leadership roles on advisory boards; and educate them about their available options and parental rights. Youth peers may support young people in self-advocacy, assertiveness, and decision-making, empower youth to lead their own care planning processes, and support them in exploring identity and navigating services with confidence and autonomy.

Advocacy is not unique to peers – other non-clinical positions, including care coordinators and CHWs, may engage in this role, but for peers it is often central. As families and youth build advocacy skills and confidence, peers shift from advocating on their behalf to preparing them to confidently use their own voice (e.g., in a school meeting).



Youth peers, in particular, are increasingly engaged in research, program design, evaluation, and systems improvement. Organizations such as Youth MOVE National and Youth Villages promote and offer tools to improve partnership with youth across systems that serve them. As credible messengers, they help agencies design services that better reflect youth needs and realities.²⁴ Youth peers' deeper understanding of youth culture also allows peers in the engagement role to assist services in changing the atmosphere to become more welcoming for young people.¹⁴

Skill-Building and Practical Coaching

Peers teach practical and emotional skills to help families and youth navigate systems, manage stress, and practice recovery in daily life. They do so not as external experts, but as fellow consumers with lived experience and formal training. Because of this credibility, their coaching is often more relatable and better received than when delivered by other staff.

Family peers may co-lead psychoeducational groups on resiliency, recovery and family functioning and provide culturally relevant education on mental health and treatment.³ They are especially effective in coaching families to recognize early warning signs, develop safety plans, and maintain stability during transitions.³⁸

Youth peers provide informal, non-clinical education and model age-appropriate strategies for managing mental health, relationships, and daily challenges. They may also teach practical life skills such as time management, communication, problem-solving, and conflict resolution, grounding these lessons in their own recovery journeys and lived experiences.

Collaborative and Administrative Functions

Family peers can be integral non-clinical members of interdisciplinary teams. They bring lived-experience perspectives into planning processes, contribute to documentation, and help advance practices that are more family- and youth-centered. Their collaboration may extend beyond direct care teams to include schools, agencies, and peer workforce initiatives, where they strengthen inclusive approaches and participate in both clinical provider and peer workforce training and system-level development. Although peers may participate in administrative activities within the scope of their own responsibilities (such as entering data for services they provide), they generally do not perform administrative tasks on behalf of clinical staff. Their distinctive contribution lies in ensuring that team processes, service plans, and organizational practices reflect the priorities and voices of families and youth, rather than in carrying out the full range of coordination and administrative tasks.

Training and Core Competencies

Appendix C identifies the core competencies included across the most commonly utilized family and youth peer support certification programs. Broadly, certification programs cover the following competency categories: advocacy and empowerment, systems knowledge and navigation, trauma-informed, resiliency and recovery-oriented, culturally responsive, person centered, voluntary, and relationship-focused service delivery, lived experience, and professionalism.

Two of the national core competency frameworks, developed by SAMHSA (2024) and FREDLA (2017), are commonly used by states and programs as best practices in training for family and youth peer support specialist roles. Their competencies are summarized below.

SAMHSA's Core Competencies for Peers:

- Engaging peers in recovery-focused relationships
- Sharing lived experience skillfully and ethically
- Supporting self-directed recovery planning
- Promoting systems navigation and community integration
- Providing culturally responsive, trauma-informed support

FREDLA's Core Competencies for Peers:

- Validating caregiver experiences and fostering hope
- Teaching advocacy and system navigation
- Modeling healthy coping and boundary-setting
- Assisting in crisis planning and special education navigation
- Building trust while respecting family culture, values, and privacy

In addition to these core competencies, ongoing professional development is important for the peer support workforce. Family and youth peer workers can benefit from specialized training focused on the specialized needs of youth and families, such as:

- The juvenile justice and child welfare systems to support families and youth navigating court systems, placement disruptions, or reunification processes
- Intellectual and developmental disabilities (IDD) to equip peers to support neurodivergent youth and caregivers, access resources from multiple state agencies, and ensure children have full access to educational resources and are cared for within the least restrictive settings possible
- LGBTQ+ youth to prepare peers to support and affirm the identities of LGBTQ+ youth and offering peer connection grounded in safety, visibility, and lived experience
- Co-occurring mental health and substance use needs to build a basic understanding of dual diagnoses and supporting youth and families in accessing coordinated, stigma-free care
- System-level advocacy and cross-sector collaboration to strengthen a network of peers and others with lived experience to elevate family and youth voice in system reform, policy development, and care team decision-making

The need for ongoing training and supervision related to boundary-setting and self-care in order to ensure that family and youth peer support specialists can effectively sustain their own recovery and wellness while supporting other family members was emphasized both in research on best practices as well as by participants of focus groups and interviews.

“Just because a child is receiving services doesn’t mean that they, or their parent, are ready to step into a peer role.”

- HOWARD SOVRONSKY, BEHAVIORAL HEALTH ADVOCATE FOR THE STATE OF CONNECTICUT

Certification

Several national organizations have developed models, guidelines, and certification standards that shape the foundational competencies for family and youth peer support. These models shape how peer support workers are trained, supervised, and integrated into behavioral health systems and serve as key references for building high-quality, equity-driven peer support infrastructure.

TECHNOLOGY IN PEER TRAINING: PARTNERSHIP TO END ADDICTION

The Partnership to End Addiction is a nonprofit organization that is dedicated to preventing and addressing substance use. Among their services is family peer support, offering text support one-on-one between parents/caregivers of youth with substance use disorder and family peer coaches.

In addition to formal online training, peer coaches are provided with ongoing training and feedback through artificial intelligence (AI). Peers practice engagement with AI-simulated family members and receive AI-generated feedback. The AI program is designed using best practices in engagement, boundary setting, motivational interviewing, etc.

These types of tailored AI-generated training tools offer peers opportunities for additional practice in a safe setting and supplements and informs supervision and follow up.



While there are some differences across certifications, all center lived experience, relational connection, and culturally responsive, person- or family-driven care. Key frameworks are briefly described below, with a detailed list of certifications summarized in [Appendix D](#).

- SAMHSA established one of the most widely adopted frameworks for peer support. [The National Model Standards for Peer Support Certification](#)⁴⁰ outlines domains such as lived experience, supervision, ethical guidelines, and training access. These standards are adaptable for youth, adult, and family roles and emphasize recovery-oriented practices, person-centered principles, and long-term support relationships.
- The Family-Run Executive Director Leadership Association (FREDLA) brings a family-driven lens to the field of peer support with its national [Parent Peer Support Practice Model](#)⁴¹ which emphasizes the unique skills of family peer specialists who support caregivers navigating child-serving systems and addresses the core competencies required for quality family peer support as evidenced by decades of family peer support provision by family-run organizations, best practices in the field, and current research, as well as the competencies outlined in the national certification.⁴²
- National Association of Peer Supporters (N.A.P.S.) focuses on values-based standards and role clarity. Their [National Practice Guidelines for Peer Specialists and Supervisors](#) addresses both peer practice and peer supervision.⁴³
- National Federation of Families (NFF) offers a defined set of [Core Competencies for Certified Family Peer Specialists](#) (CFPS).⁴⁴ These competencies address the ability to support families and caregivers across the lifespan and systems. These competencies provide the framework for the National Family Peer Specialist Certification.
- International Certification and Reciprocity Consortium (IC&RC)⁴⁵ provides a widely used framework for peer recovery credentialing within substance use settings. Its [certification standards](#) are implemented across many states and emphasize four core domains: Advocacy, Ethical Responsibility, Mentoring and Education, and Recovery/Wellness Support.
- While not focused on the child behavioral health continuum, it is important to note that a new [Connecticut Peer Support and Recovery Professional Certification \(CPSRP\)](#) was recently launched. This credential will become DMHAS' recognized standard for peer support. Approved curricula will be comprised of (1) specific training domains, including professional, legal, and ethical considerations; crisis response; recovery planning; and leadership and advocacy; (2) SAMHSA's twelve core competencies; and (3) Connecticut peer ethics and values.

What are best practices for implementing family and youth peer support services?

What employment structures are effective?

What changes may be needed within organizational culture?

What are best practices in maintaining role clarity?

What are best practices for supervision?

How can peers' career development be supported?

Implementation of peer support services requires intentional strategies to ensure they are fully integrated, respected, and valued within teams. Insights from stakeholders and best practices suggest the following approaches for successful integration.

Employment Structures

Peer support, to strengthen children's well-being, may be supported through a variety of employment structures. Peer support specialists may work either embedded within professional service teams, such as child mental health clinics, or as independent supports through family-run organizations.⁴⁶ Other models facilitate a hybrid of these employment structures (e.g., employed by a behavioral health agency but with ongoing training and supervision provided in collaboration with a family-run organization). These different approaches are associated with varying strengths and challenges which are discussed below.

Clinical Team Integration

Co-located or integrated peers within clinical service teams can be beneficial in supporting real-time collaboration, shared care planning, and enhanced trust between providers and peers. Fully embedding peers into care routines, including daily huddles and multidisciplinary team meetings, maintains the role of lived expertise in decision-making and service delivery. Challenges may include peers feeling disconnected from other peers (they are often the only one in their role in an organization or program), or supervision by staff with limited understanding of peer roles, both of which may contribute to role confusion or role drift. Additionally, it may be challenging for the peer to work with the family once they transition out of the agency, breaking continuity of care.

Independent Peer Organizations

Employment of peers by a family-run organization, the most common implementation approach, allows for independent peer voices to work collaboratively with

clinical teams. A structure independent of a behavioral health organization can support the work of a peer support specialist to follow a family across levels of care, systems or services. Family or peer-run organizations can be beneficial for maintaining peer roles from drift into other tasks not appropriate for peers. They support collegial relationships among peers and strengthen peers' skills through ongoing training and supervision by experts in peer support. Challenges can include a lack of cohesion with the clinical team, and sometimes differing perceptions on treatment plans or boundary setting.

Hybrid or Partnership Models

Hybrid or partnership models between family-run and behavioral health organizations—such as a peer support staff employed by a family-run organization but based in a mental health clinic, or contracted through a family-run organization for peer services—can strengthen collaboration across systems and services. These models allow peer support staff to be embedded within care teams while also preserving specialized expertise in peer supervision and training.

“Peer support forces us to share power.”

- HOWARD SOVRONSKY, BEHAVIORAL HEALTH ADVOCATE
FOR THE STATE OF CONNECTICUT

KENTUCKY'S PARTNERSHIP MODEL

Kentucky Youth Peer Support Specialists (KYPSS) are hired and supervised by the state's community mental health centers, but are trained and coached by the Kentucky Partnership for Children and Families, Inc., a family-run nonprofit organization in the state. The Kentucky Partnership provides tools to employers, including a [Code of Ethics](#) that guides KYPSS' work. It offers clarity on process where there are discrepancies between the employers and the Partnership's ethics codes (the employer's supersedes), and it provides all parties with a detailed delineation of roles between the employing agency and the Kentucky Partnership.



Organizational Culture

Regardless of employment structure, hiring youth and family peer support specialists often requires a shift in organizational culture. Organizations must adopt a view of lived experience as a form of expertise, equal in value to academic credentials or clinical training. Programs benefit when they elevate peer voices in policy conversations, evaluation efforts, and leadership discussions. Organizations are encouraged to utilize readiness assessments that gauge their preparedness to add peer support as team members.

Recommended practices for integrating peer support specialists with a clinical or other family support team include:

- Orienting broader staff teams to peer values, roles, scope and boundaries
- Fully integrating peer staff into rounds, huddles, or team planning meetings
- Treating peers as equal partners in planning and team meetings, and not as “junior clinicians” or “paraprofessionals”. Where possible, organizations should designate “peer champions” among leadership to advocate for peer-informed policies and foster peer role sustainability
- Ensuring peer support staff have the same access to organizational infrastructure as other staff, such as electronic health record systems, team email distributions, dedicated office space and technology access, professional development, etc.
- Regularly highlighting peer contributions in team meetings
- Providing platforms for peers to lead trainings or co-facilitate trainings for other staff, including clinicians
- Investing in workforce development by offering ongoing training opportunities as well as advancement pathways or ladders into both peer-specific leadership roles as well as non-peer roles
- Addressing secondary trauma and burnout through regular reflective supervision, access to peer support circles or networking, and trauma-informed policies

PEER READINESS TOOLKIT

The City of Philadelphia’s Department of Behavioral Health and Intellectual Disabilities Services has worked to integrate peer support services toward an improved recovery- and resilience-oriented system of care. After a decade increasing their peer support workforce, a key takeaway was the need for organizations to prepare for integration of peer support specialists.

Connecticut experts in adult peer support worked in collaboration with Philadelphia to develop a [readiness toolkit](#) to help organizations successfully integrate peers.

Connecticut has continued to support other states’ adult peer support implementation by offering Learning Collaboratives on Peer Support Integration called the Recovery Workforce Learning Collaborative. New collaboratives start every 18 months.



Role Clarity

One of the most important responsibilities an organization has in integrating peer support services is role clarification. Role confusion is a persistent challenge to peer integration and can lead to underutilization or inappropriate task assignments. Clear, written job descriptions aligned with peer-specific competencies help avoid role drift and reinforce the non-clinical, relational nature of peer work.⁴⁷

Best practice is to “**protect the peer role**” by clearly defining policies and job descriptions that reinforce lived experience as a qualification,⁴⁷ and educating teams and supervisors on appropriate scope to avoid role drift into clinical or administrative functions.^{48,49} Additionally, organizations need to ensure that staff have clarity on how peers are integrated into the broader team and organization.

Due to the relational proximity between peers and those they support (especially for youth peers close in age to those they support), clear boundaries and risk management protocols are essential. Written guidance should cover dual relationships, community overlap, and social media boundaries.⁴⁷

Supervision

Supervision is a critical infrastructure element for sustaining high-quality peer support services in children’s behavioral health. To be effective, supervision must be responsive to the distinct emotional needs, developmental stages, and lived experience expertise of both Family Peer Support Specialists and Youth Peer Support Specialists. Grounded in resiliency and recovery-oriented, trauma-informed, and strengths-based approaches, supervision should prioritize role integrity, emotional wellness, professional growth, and equity in interdisciplinary teams.

Reflective supervision, while not always available, can be an effective approach to peer supervision. It creates structured space for peer staff to process their emotional responses, examine personal boundaries, and reflect on how their lived experience influences work with youth and families.⁵⁰ Reflective supervision helps mitigate compassion fatigue by acknowledging the emotional toll of peer work and providing emotional containment and validation.

Youth peers are often in the early stages of their own vocational development and may be entering their first professional role. Supervision must therefore incorporate structured coaching in workplace skills, such as: organizing tasks and managing time, writing service notes and using agency documentation systems, and navigating professional communication and workplace norms.⁵¹ Notetaking should be minimized to avoid inferring unnecessary power dynamics or interfering with relationship-building. It should focus on what is necessary for billing or to benefit service delivery to youth.⁵² Youth peer staff also benefit from written guidance, check-ins on task progress, and example-based learning. Effective supervisors model how to give and receive feedback, co-regulate stress in the workplace, and articulate challenges constructively in team settings. Especially for youth peers, supervision should include frequent and informal access to support through in-person, text, or phone check-ins. These touchpoints provide real-time emotional debriefing, problem-solving support, and encouragement to seek help before challenges escalate.

Peer workers often carry vicarious trauma and cumulative stress from long-term caregiving and system navigation. Supervision must offer space for wellness planning and self-care strategies, emotional check-ins and coping support, and boundary reinforcement and emotional containment.

Supervisors should have lived experience and training in peer support values and effective support of the peer workforce. They help reinforce peer-specific competencies, navigate boundary issues, and prevent “**role drift**,” when peers are asked to perform tasks outside their scope.⁴³ Supervision should be routine, collaborative, and strength-based, encouraging reflection, and professional growth.

“If you’re not taking care of yourself, you’re projecting what you’re feeling on the families that you’re supposed to be supporting.”

- CONNECTICUT FAMILY PEER LEADER

Supervision should intentionally celebrate small wins, which reinforces motivation and counters the discouragement that can result from inconsistent progress in youth and family work. These affirmations strengthen peer self-efficacy and resilience, particularly for youth peers learning to trust their own voice and professional identity.⁵¹ Career development conversations promote motivation, prevent burnout, and validate the professional use of lived experience.

National guidelines recommend the use of three primary supervision approaches, each serving distinct, complementary purposes: ^{37, 48, 43, 53}

INDIVIDUAL SUPERVISION

Offers a confidential, one-on-one space for emotional reflection, performance feedback, skill development, and problem-solving. This format is particularly important for addressing sensitive topics such as boundary concerns, vicarious trauma, or workplace stress. Supervisors can tailor support to the peer's developmental stage, lived experience, and current role demands.

GROUP SUPERVISION

Allows peer workers to learn from one another, share strategies, reduce professional isolation, and normalize challenges common in peer work. It reinforces community, collective problem-solving, and skill sharing across teams.⁵⁴ For youth peer specialists in particular, this format can foster mentorship, mutual accountability, and professional identity.

CO-SUPERVISION/DUAL SUPERVISION

Widely recognized as best practice, especially when peers work in non-peer-run environments or interdisciplinary teams.⁴³ This model pairs a peer supervisor (focused on mentorship, role fidelity, and ethics) with a supervisor that is on site at the work location to improve integration into team workflows. This model reduces role confusion, protects against "peer drift" (e.g., being asked to perform clinical or case management tasks), and reinforces peer identity and integrity in team settings.



What are best practices for funding and sustaining family and youth peer support services?

Sustainable financing is critical for strengthening family and/or youth peer support services for children with behavioral health needs. Consistently, states with long-standing family or youth peer support programs identify the need to blend multiple sources of funding in order to cover the true cost of the service, to diversify funding sources to weather economic and political changes, and to allow for innovation in implementation.^{53,55} There has been limited success in private insurance companies reimbursing for peer support services (there are examples in Oregon and several other states), and therefore insurance sources primarily reflect Medicaid as the payer.

States and programs braid one or more of the following sources to sustain programs:

- Fee-for-service insurance reimbursement
- Alternative or value-based insurance payments
- Medicaid waivers
- State or federal grants
- Private grants or fundraising
- Earned income

Medicaid Funding

Medicaid is a primary funding source for peer support services in most states. According to a 2019 report,⁵⁴ Medicaid coverage for family and youth peer support services was available in 33 states (and more for adult peer services). The Centers for Medicare and Medicaid Services (CMS) has identified youth peer support services as well as family peer support (as long as the identified child is enrolled in the Medicaid program) as evidence-based practices that “can be an important component in a State’s delivery of effective treatment”.⁵⁷ The Children’s Health Insurance Program (CHIP) can also be used to pay for peer services. CMS defines peer support services as, “an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders.”³²

Medicaid coverage can occur through the following payment models: fee-for-service reimbursement, value-based payment methods, and waivers:

Fee-for-service reimbursement is a beneficial option for states as it can typically be applied across various settings and service types. Depending on Medicaid state rate nuances, it often does not cover all services provided by a peer or support a living wage. It is crucial in fee-for-service modeling that reimbursement rates are inclusive of health benefits, market-based wages, and productivity models which are accommodating to time away for job development and continuing education.

Value-based payments, or per member per month payments, offer programs the flexibility to bring in peer support services where, when and how it will most effectively meet the families’ needs. Models such as Certified Community Behavioral Health Clinics (CCBHC)

may be implemented with per member per month Medicaid funding (instead of fee-for-service CCBHC reimbursement) and have the opportunity to embed family and youth peer support services to strengthen outcomes. Other states have a bundled payment for Wraparound services which allows flexibility for a peer support specialist in addition to a care coordinator, or offered a bundled rate for varied services to support youth transitioning from child to adult services.

Medicaid waivers are a common funding mechanism for states’ peer support programs, allowing peer support to be covered through Medicaid funding as a part of a global package of services, such as the 1115 substance use or mental health waivers. Peer Support

can be implemented in a variety of models through 1915 managed care waivers as well. In these managed care waivers, the administering companies under contract with Medicaid are expected to provide a base benefit package in a state contract which can include a standard Peer Support model, and managed care companies have the flexibility to also provide bonus models which meet the needs of beneficiaries, including targeted peer supports (often called an “in lieu of service” (ILOS) which is an alternative service or setting offered by a health plan that substitutes for a standard Medicaid-covered benefit, provided it is medically appropriate and cost-effective).

In any children’s services conversation related to Medicaid it is important to reference Medicaid’s Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) mandate. According to the CMS website, “States are required to furnish all 1905(a) Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions.”⁵⁸ Therefore, a state may consider peer support as a child-centered, medically-necessary service that emphasizes the role of the service in prevention and wellness and is core to symptom reduction and resilience. If there is a gap in recovery-oriented services such as peer support, then further planning and development of this service should be contemplated.

Wendy White Tiegreen is an expert in Medicaid financing of peer support services, recently retired from the Georgia Department of Behavioral Health and Developmental Disabilities, and has been consulting with other states for over 20 years. In an interview with Ms. Tiegreen, she recommended forecasting a multi-year financial plan that offers legislators cost projections, any anticipated savings, and strategies for long-term sustainability for peer support services. This plan can address concerns regarding risk and build legislative confidence. She further recommended that peer support services are most effectively and sustainably funded by Medicaid when they are included in the full continuum of care, inclusive of prevention, early intervention, and integration across all levels of care. SAMHSA SPARK had been in the process of developing a toolkit to assist states with implementing Medicaid funding for peer support. However, the project was discontinued following the termination of federal funding.

“Medicaid serves as the most stable, sustainable revenue source for peer support services.”

- WENDY WHITE TIEGREEN, NATIONAL EXPERT
IN PEER SUPPORT MEDICAID FUNDING

Common considerations for states to address in order to add family and/or youth peer support in their state Medicaid plan include the following:^{32, 57}

- Identify the Medicaid mechanism to be used for coverage and payment, the unit of service, the provider of the service, and their qualifications. These may include the Medicaid Rehabilitation Option, a 1915(i), or other alternatives.
- Describe utilization review and reimbursement methodologies and assurances that overbilling will be prevented.
- The process in which Peer Support providers should:
 - Be self-identified as consumers or caregivers/family members of consumers who are in recovery from mental illness and/or substance use disorders.
 - Be trained, certified and meet ongoing continuing education requirements.
 - Be supervised by specific professions (including experienced Peer Specialists) as designated within state policy, rule, or regulations.⁴³

OREGON MEDICAID COVERAGE FOR PEER SUPPORT

Oregon’s Medicaid State Plan includes billing codes for both family and youth peer support services. Eligibility for reimbursement requires training and certification by state-approved program authorized by the Oregon Health Authority. Reimbursement covers near or all costs of the service for Medicaid-covered children. There are also a small number of commercial insurers who cover peer support services within a bundled rate (e.g., for intensive in-home services).

Grants and Other Funding

In addition to Medicaid, states utilize various funding streams to support peer services, including the Substance Use Prevention, Treatment, and Recovery Support Block Grant, Community Mental Health Block Grants, and State Opioid Response (SOR) Grants. Federal funding mechanisms, such as SAMHSA discretionary grants (including the Children's Mental Health Initiative/System of Care, Statewide Family and Consumer Network grants), also play a critical role in expanding peer support services. Programs such as the Building Communities of Recovery (BCOR) and the Recovery Community Services Program (RCSP) provide targeted funding to support grassroots peer-led initiatives.

SAMHSA's 988 Grants and the Cooperative Agreements for 988 Suicide & Crisis Lifeline Crisis Center Follow-Up Programs have also facilitated the integration of peer workers into crisis response settings, ensuring that peer specialists play a key role in suicide prevention, and crisis intervention (e.g., SAMHSA's Peer Recovery Center of Excellence).

Grants may be specific to implementing a peer support program, may expand coverage of peer support services to commercially insured children, or may supplement other funding in order to cover the full cost of services and ensure that peer support specialists receive a living wage. While a less reliable or predictable option, nonprofit providers often rely on traditional fundraising to cover peer support costs. Some also engage in earned income strategies (e.g., offering statewide training and certification of peers, and in-turn using training and certification fees to support implementation of peer services).



What is the current landscape of family and youth peer support within Connecticut and how does it compare to identified best practices?

What programs are currently employing family and/or youth peer supports?

How are these programs currently funded?

What training and certification programs are available?

Connecticut has a strong foundation to build upon as it works to expand the integration of family and youth peer support within the children's behavioral health system. Stakeholders across the state, including caregivers, providers, and peer leaders, express high enthusiasm for peer roles, and the value of lived experience is increasingly recognized by policymakers and state agencies.

Family peer support efforts to date are significant in reach and impact, however have not been funded or implemented on a system-wide level. The current family and youth peer support programs available in Connecticut are summarized below and a comprehensive list is included in [Appendix E](#).

Connecticut Family Peer Support Programs

Connecticut is home to multiple long-standing family-run and family support organizations that provide families with training and support to assist with navigating the various systems families encounter (e.g., behavioral health, child welfare, developmental services, juvenile justice, education). There are examples of family peer support specialists embedded within behavioral health organizations to support families with DCF involvement, crisis services, and other system involvement. Some organizations (e.g., NAMI-CT) offer peer support groups (informal peer support) for parents and caregivers of youth with behavioral health needs.

There are also family-run organizations, e.g., FAVOR and AFCAMP, providing more formalized peer support services to the parents and caregivers they serve. Wraparound services frequently engage family peer support specialists as informal supports within families' "child and family teams." In interviews with family members, this was frequently the source of their initial referral to a family-run organization. These family members referenced the benefit of being able to stay with the peer support specialist following discharge from their six months of Wraparound supports. FAVOR is Connecticut's statewide family support organization identified through SAMHSA's System of Care grant. Through a team of trained Family Support Specialists and Peer Support Specialists, FAVOR provides individualized



support to caregivers navigating mental health, substance use, juvenile justice, and educational systems (over 90% of families served by FAVOR need support in working with their child's school as a component of services).

At the time of publication, DCF had recently launched a new youth peer support program for youth ages 12-17 with co-occurring (substance use and mental health) concerns, as well as youth re-entering community and home from juvenile justice settings. Highlights are included below and more detail is offered in [Appendix E](#).



Connecticut Youth Peer Support Programs

Youth Motivating Others through Voices of Experience (Youth MOVE) National is a nonprofit organization that works to develop youth advocates for system change, and also trains young adults as youth peer supports. Initiated in part with funding from SAMHSA, Youth MOVE National now has 40+ local chapters, but not yet one in Connecticut. There have been, however, a limited number of youth in Connecticut who have completed the Youth MOVE National Youth Peer Support curricula through partnerships with Advocacy Unlimited and FAVOR.

There are additional youth-focused recovery programs in Connecticut, such as Youth Recovery CT, SMART Recovery (Teen), and Positive Directions 1:1 Peer Support, while not certified, and largely volunteer driven, they provide mentoring or lived-experience coaching.

CT Support Group (formerly TurningPointCT) is an initiative developed by young adults and is supported by DMHAS. It provides digital content, peer groups, and one-on-one support to young adults from a certified youth peer support specialist. Through additional funding, CT Support Group also provides services to youth. While the initiative is small in scale (i.e., there was only one peer staff member at the time this report was developed), it serves as a promising example of an age-appropriate support model and provides exposure to core competencies like boundary-setting, resource linkage, and empathy-driven communication.

Connecticut Peer Support Certification Programs

Connecticut has implemented several peer support training and certification programs which are aligned with national certification models and core competencies. These are briefly described below.

Family and Youth Peer Training and Certification

In Connecticut, family peer workers are certified through the Family Support Certification (FAVOR), and the National Certified Family Peer Specialist Certification (National Federation of Families for Child Mental Health). Several peer support supervisors have completed the Supervisor training through the national Parent Peer Support Practice Model (FREDLA). FAVOR's training is aligned with the National Federation of Families for Child Mental Health certification competencies, and is a formal state certification for family peer specialists. FAVOR trains family members who have received services from FAVOR and are ready to support other parents or caregivers toward two formal paid roles: (1) Family Systems Manager, and (2) after completion of the full training and certification, Family Peer Support Specialists. These are both paid positions at FAVOR (certification also makes families eligible to work in other settings hiring peers).

In August 2017, Connecticut state partners including FAVOR, AFCAMP, Parent-to-Parent Voices of Connecticut, Elevance Health, children's behavioral health providers, and family members collaborated with Millie Sweeney from FREDLA (also the SAMHSA TA provider for this project) to develop *The Connecticut Certification Manual for Family Peer Support Liaisons and Family Peer Support Specialists* which provided guidelines and tools for Connecticut to offer family peer support certification. The manual addresses competencies, activities, supervision, a code of ethics, and certification processes, and continues to be a resource for the state that can be leveraged in expanding peer support services.

Additional family peer training opportunities include: NAMI CT Trainings which prepare family members to lead peer support groups and provide psychoeducation. These services are primarily in volunteer contexts. Intentional Peer Support (IPS) is a nationally recognized approach emphasizing power-sharing and mutuality that has been completed by some Connecticut peer workers via out-of-state training partnerships with the Wildflower Alliance, a grassroots advocacy organization located in Holyoke,

Massachusetts. For youth, Advocacy Unlimited (AU) has piloted adaptations of RSS training for young adult peers, including added content on trauma, oppression, and cultural responsiveness.

In Connecticut, youth peer specialists are certified through the **Youth Peer Support Specialist Certification** (Youth MOVE National), **Recovery Support Specialist Certification** (Advocacy Unlimited), and the **Peer Recovery Support Certification** (CT DMHAS). These are aligned with national best practices, however, few youth peer support positions are funded, and therefore few youth have received training and certification to date. For the adult (18+) DMHAS-funded service system, the new CPSRP credential that launched in 2026 will be the certification recognized for peer support roles.

At the time of publication, DCF is in the process of with organizations such as AU to develop training for peers to serve youth ages 12-17 with co-occurring (substance use and mental health) concerns, as well as youth re-entering community and home from juvenile justice settings.



Adult Peer Training and Certification

Connecticut's new Certified Peer Support and Recovery Professional (CPSRP) credential launched in 2026. The creation of this newly recognized credential has been facilitated by the DMHAS Office of Recovery Community Affairs, in collaboration with the organizations and individuals in the peer support workforce. It is designed to formalize and unify adult peer recovery roles across the state. The credential is voluntary and will be administered by the Connecticut Certification Board (CCB). Those currently working in the peer support field will be eligible for a grandparenting process if they previously completed

an approved training program or hold an International Certification & Reciprocity Consortium (IC&RC) credential. To be eligible for the certification exam individuals must first complete 80 hours of training at one of the approved training programs.

Before the launch of this new credential, the state has had three DMHAS-recognized training providers (Advocacy Unlimited, CCAR, and Hartford Healthcare Recovery Leadership Academy). More context on these trainers and the transition to the new credential is provided [Appendix D](#).



Connecticut Peer Roles

A primary goal of the non-clinical behavioral health staff survey was to identify the current roles of peers locally, as well as how they do or do not overlap with those of other non-clinical staff. Analysis of survey responses found that staff in peer roles consistently rated relational and engagement-based tasks (e.g., providing emotional support, advocating for families, encouraging engagement, and sharing personal stories) as both highly important and frequently performed. Peers also rated both advocacy and stabilization support highly, aligning with their roles in supporting people through recovery or caregiving journeys. See [Figure 1](#) for more details.

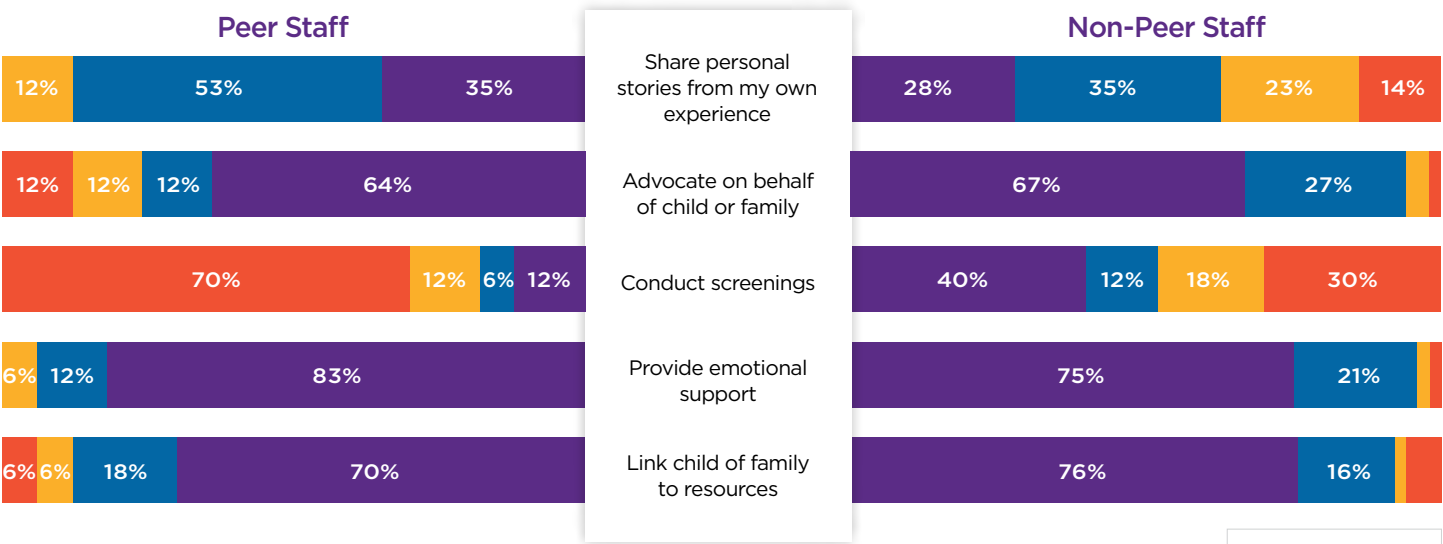
Peer staff were especially distinct in their frequent use of strategic personal storytelling and peer group facilitation, which were rated as peripheral or not applicable by those in non-peer roles. They consistently rated clinical and administrative tasks such as intakes, screenings, and discharge planning as less important and infrequently performed.

In contrast, non-peer roles (i.e., case managers, care coordinators, and CHWs) reported a broader scope that included more formalized care coordination, administrative, and assisting with clinical responsibilities. Non-peer roles were more likely to rate tasks such as linking to resources,



conducting screenings, coordinating appointments, and attending external meetings as both important and routine. While emotional support and advocacy were also valued by these roles, the emphasis was more distributed across a wide array of responsibilities.

Figure 1. Peer vs. Non-Peer Staff: Frequency of Key Activities



Note. Peer staff (n=19) included youth peer support specialists, family peer support specialists, and recovery support specialists. Non-peer staff (n= 54) included non-licensed behavioral health professionals, such as case managers, care coordinators, community health workers, and community navigators. Response categories reflect the frequency with which respondents reported engaging in each activity (Always/Frequently, Sometimes, Rarely, Not at all).

LEGEND:
Always/Frequently
Sometimes
Rarely
Not at all



Opportunities to Strengthen Family and Youth Peer Support in Connecticut

Connecticut is well-positioned to grow its peer support infrastructure. The state has a high level of interest among stakeholders, families, and providers to expand peer roles, and existing strengths in family- and youth-led organizations, training resources, and pilot programs. Connecticut's peer support workforce has leveraged a variety of training programs (both within and outside the state) to build foundational skills in advocacy, trauma-informed support, and systems navigation. These offerings have helped seed a growing, mission-driven workforce across family, youth, and recovery contexts. However, as demand increases, stakeholders emphasize the need for more consistent, coordinated, and developmentally-tailored training pathways.

Several gaps in peer support services remain.

The following offer opportunities to expand the role of family and youth peer support to benefit the state's children and families.

- Very few youth-specific peer roles, or training or certification opportunities exist statewide.
- Family peer roles are not available for most providers and serve only a small fraction of families who could potentially benefit from peer services.
- Roles and responsibilities vary across programs and sometimes overlap with other non-clinical positions.
- Peers lack a clear career ladder with professional advancement opportunities.
- Training and supervision structures vary widely across programs.
- Funding remains grant-dependent and vulnerable to disruption.
- Connecticut providers and family leaders emphasized that structured onboarding should include all staff—not just peers—to build shared understanding of peer functions.



Connecticut Peer Support Funding

At present, Connecticut's Medicaid program does not reimburse family or youth peer support services. The state does have a substance use disorder (SUD) 1115 Medicaid demonstration waiver that includes peer support as part of the residential reimbursable staffing pattern. The absence of sustainable, systematic funding remains a key barrier to the full and equitable integration of the peer support workforce. Recent state legislation has added Medicaid reimbursement for doulas (also a non-clinical healthcare role). Note that while there was also legislation passed regarding coverage for CHWs, funding was not allocated, and therefore their services are not yet reimbursable at the time of publication. This legislation offers a potential path the state may learn from to expand reimbursement to peers. The newly reimbursable doula services required legislative changes to Medicaid policy as well as a basic certification added by the Department of Public Health (DPH). The certification does not necessarily add requirements to the professions' existing qualifications, but instead verifies completion of those qualifications. The DPH certification is consistent with existing mechanisms that DSS uses to verify eligibility for reimbursement of services provided by other health professionals.

At present, family and youth peer support services in Connecticut are primarily supported through a patchwork of limited funding mechanisms:

- State agency contracts such as DCF's contract with FAVOR
- Federal grants such as SAMHSA's System of Care awards
- Agency operating budgets or volunteerism, especially where formal funding is absent
- Braided funding models, which rely on a mix of grants, private philanthropy, and fundraising

What are the potential system-level benefits of expanding family and youth peer support services?

Connecticut, like most states, is experiencing a variety of system-level challenges with meeting the behavioral health needs of children and families, including workforce shortages, long waits for services, high costs of care, coordination of care across systems, racial and ethnic inequity in access, completion of treatment, and outcomes, as well as disproportionate needs among vulnerable populations, such as LGBTQ+ youth. As demonstrated earlier in the report, peer support services can improve the engagement in and satisfaction with treatment. Additional benefits of peer support services offer opportunities to address system-level challenges in Connecticut, and the behavioral health workforce shortage in particular.

Research on peer support services demonstrates the impact it can have on children and families' engagement in services, completion of treatment, understanding of their care plan, social connectedness, emotional well-being, and overall functioning. While much of the research on system-level outcomes has come from adult peer support services, multiple studies have found reduction in length of hospital stays, rates of re-hospitalization, use of emergency departments, and overall service use; resulting in an overall reduction in costs to the system.⁵⁸

Should family and youth peer support services be intentionally and strategically expanded within the state, peer support services have the opportunity to improve equity in access to services and treatment outcomes, increase access and decrease wait times for prevention and early intervention services, increase engagement in treatment, and in the long-term alleviate strain across the workforce and use of higher levels of care.

Equity

Family and youth peer support services have been found to be effective in reducing stigma and improving engagement in behavioral health treatment, in particular for youth and families who have been historically underserved, including youth of color and LGBTQ+ youth, ultimately increasing equitable access to care.¹³ A study of Latine youth transitioning from foster care to independence found that peer support networks helped with securing housing, economic support, and emotional coping to counteract the psychological distress associated with foster care experiences.⁷ Similarly a study of peer support for youth who were immigrants or refugees found it facilitated trust-building, reduced isolation, and improved mental wellness, making them a valuable resource for promoting service engagement and resilience in immigrant communities.²⁷ Intentionally serving youth who are traditionally underserved, such as youth of color, immigrant youth and LGBTQ+ youth, through peer support services from family and youth peers from shared communities and identities has the opportunity to close some of Connecticut's gaps in equity for access to and completion of treatment, as well as enhanced treatment outcomes.



Prevention and Early Intervention

While the research is limited, there is promising reason to expect that implementing peer support services as a prevention or early intervention strategy could address needs for at-risk youth or youth with low acuity behavioral health concerns.

Connecticut could consider implementing peer support in the following prevention, early intervention, or “bridge” capacities:

- For youth identified as “at risk” for behavioral health concerns, or with needs that are very low in acuity, youth peer support could be implemented as a prevention, early intervention, or harm reduction strategy. Youth peer support specialists can provide emotional support and psychoeducation to strengthen children and youth’s resilience and well-being. Peer support specialists could also help the child and family navigate systems and services to find care should symptoms worsen.
 - In these cases, peer support can be offered as a component of a stepped-care model, which seeks to offer the least intensive and restrictive intervention required to support a given behavioral health need, inclusive of self-help or support group strategies for lower-level needs, and more intensive treatments offered as needed. There is evidence to support both symptom reduction and cost-effectiveness of stepped-care models.⁶⁵
 - While not traditionally part of peer support services, youth peers could be trained on single session consultation, which is a brief, “solution-focused session that empowers people to take a **small, feasible, and meaningful next step** towards a goal that matters to them.”⁶⁰ Implementation of single session consultation would be consistent with peer support roles, including prioritizing the youth’s goals and wishes, providing psychoeducation, and co-creating an actionable plan.
 - Note that these **prevention** services by youth peers will require infrastructure development to support not only the expansion of the youth peer workforce, but subsequently outreach to referral sources (e.g., pediatricians, schools, etc.) to promote referral to youth peers and education on which needs are appropriate for the service. This component of peer support services can be phased in as the youth peer support workforce is further developed.
- Peer support services could also be implemented as a “bridging” service for families on a wait list for services or for families transitioning out of care who need support returning to community and school. Peers can help maintain contact and provide support for system navigation while families wait for appointments for longer-term care. For example, following discharge from emergency departments or urgent crisis centers, families sometimes wait several weeks before connecting with care and may experience disruptions in family life or additional crises that can escalate symptoms or present additional challenges while trying to navigate systems and services. Peers can maintain the connection to systems during these times.





Workforce Challenges

There is limited ability for peer support services to meet **short-term** workforce needs. “Task shifting” of work from clinical staff to the non-clinical workforce (i.e., tasks such as screenings, data entry, administrative support which do not require the expertise of a clinician) is sometimes raised as a strategy to reduce clinician workload. Most roles are unique and distinct from the work of clinical and non-clinical staff, *and* “shifting” work onto peers would be inappropriate implementation of peer support services, inconsistent with best practices in peer support roles.

In the long-term, however, implementation of peer support services can help alleviate the children’s behavioral health workforce needs. By improving effectiveness of behavioral health services through improved engagement in and completion of treatment, by reducing re-hospitalization, and by shifting service delivery where appropriate from intervention to prevention/early intervention, eventually it can be expected that there will be lower caseloads for clinicians.

How can family and youth voice be expanded throughout the children's behavioral health system (in addition to the employment of peer support specialists)?

Providers

Recruiting more individuals with lived experience into roles across the behavioral health workforce, including clinicians, other care staff, and leadership can be beneficial to the design and delivery of services. Additionally, providers may engage youth and their family members in advisory roles for the agency and its programs to bring the lens of lived experience to decision making. Many providers already work with their clients across these various stages of engagement.

Note that hiring those with lived experience into clinical roles and other positions is important, but *serves a different purpose* than the integration of family and youth peer support specialists (the focus of this report). The elements of strategic personal storytelling to build rapport and providing emotional support through shared experience are central to peer roles in ways that would typically be crossing boundaries for other staff.

State Agencies

State agencies also have the opportunity to hire staff with lived experience and include them in decision-making roles and advisory bodies. While lived experience can be a benefit to filling existing positions, it is also possible and effective to create *new positions* explicitly to elevate a lived experience lens. As an example, DCF has just recently added a *Parent with Lived Expertise Consultant* to its staff within the Commissioner's office. In interviewing the parent who is now employed in this position, she emphasized her dual role: supporting families as they receive DCF interventions, but also shifting the culture of the DCF workforce to understand the perspectives of families better, and improving the interactions between DCF and families, leading to better outcomes for families overall.

Advisory Bodies

Per the System of Care principles, governance bodies should be comprised at least 51% of family and youth, and youth and families should hold leadership roles (such as co-chairs of committees). In addition to the CBHPIAB, children's behavioral health advisory bodies in Connecticut include: the Children's Behavioral Health Advisory Committee (CBHAC), Statewide Advisory Council (SAC), Behavioral Health Partnership Oversight Council (BHPOC), Transforming Children's Behavioral Health Policy and Planning Committee (TCB), and other system-related bodies, such as the Juvenile Justice Policy and Oversight Committee (JJPOC).

While nearly all of these groups have parents or caregivers with lived expertise within their membership, only CBHAC has family members with lived expertise as the majority of their membership. There is an opportunity to expand the roles and leadership of those with lived experience throughout Connecticut's systems for children and families.

INTEGRATED CARE FOR KIDS

The Integrated Care for Kids (InCK) model is a Centers for Medicare and Medicaid Services grant program, locally implemented in New Haven by Clifford Beers. The model provides a per child bundled payment from Medicaid (instead of fee-for-services), emphasizes early intervention and provides both physical and behavioral health interventions. Depending on level of needs, families are provided with intensive care coordination using the Wraparound approach. In Connecticut, Clifford Beers embeds lived expertise in the work, especially among the care coordinators, allowing lived experience to substitute for educational requirements in many cases. A parent advisory group was engaged early to shape implementation, and make decisions regarding, engagement, care, and other aspects of implementation.

RECOMMENDATIONS

There is strong evidence that family and youth peer support services can strengthen effectiveness of children's behavioral health services, and support system-level improvements. Additionally, Connecticut has a strong infrastructure of peer support training, certification, and service delivery upon which to build. The following recommendations and action steps provide a framework for Connecticut to expand upon the existing strengths to broaden the reach of family and youth peer support services within the state. An action plan summarizing key steps from the recommendations is also provided.





RECOMMENDATION 1

Secure insurance coverage of services provided by peer support specialists.

Change Connecticut Medicaid policy (through a state plan amendment) to allow reimbursement for services offered by peer support specialists (inclusive of adult, youth, and family peer support specialists or recovery specialists). Medicaid fee-for-service reimbursement of peer support services would allow flexibility in types of programs that receive reimbursement and should be designed so that both behavioral health agencies as well as family-run organizations can bill Medicaid. Action steps will require legislation that enacts the change in the service plan and also allocates funding to support implementation of peer-provided services (sufficient to provide a living wage to peers). **To provide DSS with the verification of peer certification necessary for reimbursement, DPH will need to provide peer certification** for each type of peer.* This certification from DPH *should not add requirements* for peers, but instead just verify completion of training and certification from a list of existing, approved peer certifications (see Recommendation 2). Advisory bodies, such as the TCB, may be well-positioned to collaborate with DSS, DMHAS, DCF, CBHPIAB, CBHAC and others to inform or draft legislation.

While uncommon, there are examples of private insurance coverage of peer support services. The Connecticut Insurance Department (a member of the CBHPIAB) may be well-positioned to identify opportunities and strategies for adding reimbursement of peer services by commercial insurers.

In addition to fee-for-service reimbursement, opportunities for flexible Medicaid funding through value-based or bundled payment options should be pursued. CCBHC is currently in its planning phase in Connecticut, with anticipation that the model will be subsequently funded by the Centers for Medicare and Medicaid for implementation. As implementation moves forward, clinics may utilize the opportunity of flexible funding design to incorporate peer support services. Connecticut has been seeking to add insurance reimbursement for care coordination, and Wraparound in particular, for many years. **The state should also develop a bundled payment for Wraparound that would allow for reimbursement of care coordination services and inclusion of peer support services when appropriate.**

*Note that DPH has an existing certification for community health workers with a broad definition. It may be possible that peer support specialists and their associated list of approved training programs could be added to this existing certification. While this report as well as broader research identify key differences between community health worker and peer support specialist roles, the DPH language is intentionally broad to allow for the flexibility needed for effective community and family engagement services.



RECOMMENDATION 2

Expand access to existing family and youth training and certification programs.

Across the children's behavioral health system (inclusive of prevention and intervention services), family and youth peer support specialists should be trained and certified with consistent standards informed by best practices and experts in the field of peer support. Connecticut has a strong foundation for its current training and certification of family peer support specialists (Connecticut Family Peer Support Specialist Certification), which is based upon national best practices and aligned with the National Federation of Families for Child Mental Health certification competencies.

Connecticut should continue to use this training and certification program and expand it to train and certify more family peer support specialists. The state should provide **grants to family-run organizations to offer the training and certification** at little or no cost to parents and caregivers with lived experience who are ready in their wellness or recovery journey with their child to become family peer support specialists.

The training, certification, and employment of youth peer support significantly lags behind family peer support in Connecticut. The state also has gaps in engaging youth in its decision-making structure. Similar to the family peer support certification, **the state should support organizations to offer youth peer support training and certification aligned with best practices and expertise from the field of youth peer support (such as Youth MOVE National).** The new investment in youth peer training for young people with co-occurring substance use/behavioral health needs should be assessed for potential expansion.

Ongoing professional development opportunities should be funded and required to maintain certification, and should both ensure core competencies are maintained over time, but also **enhance certification through trainings on topics that address gaps in the system and build capacity of peers to serve underserved populations**, including: youth with juvenile justice or child welfare involvement, children with intellectual and development disabilities, LGBTQ+ allyship, and substance use and co-occurring disorders.

Connecticut has extensive training opportunities for the behavioral health workforce, including in-person, remote, and asynchronous options. As relevant, these should be extended, and tailored as needed, to peer support specialists.

The state should also engage in innovative opportunities to build upon peer support efforts based upon promising practices. This includes **training family and youth peers on single session consultation** (see Recommendation 5). Additionally, innovative and emerging approaches to training should be considered, such as AI-driven platforms already being used by some states to efficiently simulate peer interactions and receive feedback on performance to meet standards.



RECOMMENDATION 3

Strengthen behavioral health programs' capacity to integrate peer support services.

Behavioral health agencies should utilize an organizational readiness tool, such as [Building Organizational Readiness: A Peer Recovery Center of Excellence Toolkit](#) or the [Recovery Workforce Learning Collaborative Toolkit](#) used within Connecticut for adult services, to help them assess what organizational changes will strengthen their preparedness to integrate peer support into their workforce.

The need for effective supervision of peers is one of the most critical elements of peer support implementation. Peer supervision must be aligned with peer support values and incorporate best practices. Supervisors of peers ideally have experience as a peer support, but absent that possibility, peer supervision models must incorporate: common understanding of peer roles, boundary coaching, reinforcing the ethical scope, preventing role drift, supporting resiliency and recovery-informed self-care, centering peer roles over clinical assumptions, acknowledging ongoing lived experience without stigma, creating a space of curiosity, non-judgement and reflection. This supervision approach should be backed by clear job descriptions and peer scope policies. **The state should fund the adoption of a training for peer support supervisors as well as support of a supervisor learning collaborative as an opportunity for ongoing professional growth.**

The CBHPIAB members (or a subcommittee), inclusive of representatives from family-run organizations, family and youth peer support specialists, and providers, should **develop a written tool or template for organizations to use that offers clarity on peer support roles and distinguishes them from other non-clinical roles.** As referenced within this report, multiple tools exist across other states that may serve as a template to build upon or adapt within Connecticut. This will support behavioral health programs to integrate peers within service delivery and avoid role confusion which is often a barrier to successful peer support implementation.

The tool should include the following core roles: engagement and relationship building, emotional support and mutuality, system navigation, advocacy and empowerment, skill building and practical coaching. It should also include examples of the role in practice and how it looks different from other non-clinical staff roles.

Both literature and survey responses indicate that more clarity is needed regarding career ladders or pathways for the peer support workforce. **A Connecticut-specific career pathway for family and youth peer support specialists should be developed.** The pathway should be inclusive of peer supervisory roles, other designated “lived expertise” roles within the states, but also other roles within the child-serving system (e.g., care coordinator, home visitor, social worker, licensed clinician, quality assurance/compliance, workforce development/trainer, etc.). The pathway should clarify the role of each as well as the educational, training, certification and/or licensing requirements. **As funding allows, agencies should provide financial assistance for peer support specialists to seek education to advance within the behavioral health field.** For youth, the career pathway should demonstrate opportunities for advancement as a peer supervisor, as an adult peer support specialist, other career opportunities within the child-serving system, but also how the professional skills gained as a youth peer support specialist are transferable to other fields.



RECOMMENDATION 4

Prioritize identified behavioral health services and family and youth needs as funding becomes available to expand the peer support workforce.

As funding for peer support services becomes more widely available through insurance reimbursement, state grants, and other sources, and as the peer support workforce continues to grow, the state should prioritize investments in services that align with research-based best practices and are most likely to improve outcomes for children, families, and the broader behavioral health system. The state should also maintain flexibility in service delivery models, allowing either behavioral health providers or family- and youth-run organizations to serve as the lead employer while encouraging strong partnerships between the two.

As funding and workforce capacity expand, all youth and families should be offered peer support services across the following levels of care:

- **Higher levels of care, including psychiatric or substance use inpatient care**, with peer support as a regular component of treatment plans as well as for discharge to support the transition while stepping down into subsequent services. In these types of services, it may be most effective to directly embed family and youth peer support specialists as members of the providers' care teams with connections to peer led organizations for support and learning.
- **Crisis services** (mobile crisis and urgent crisis centers) as well as emergency departments can benefit from offering all families and youth peer support services. These settings may benefit from either embedding peer support services or partnering with a family-run organization to employ peer support services.
- **Care coordination** using high fidelity Wraparound is another intervention that has demonstrated benefit from including family peer support and is already implemented regularly in Connecticut by behavioral health agencies who partner with family-run organizations. This allows peer support services to extend, if needed, beyond the (typically) 6-month timeframe of Wraparound.

Regardless of the level of care or service type, there are specific needs or characteristics among children and families that may make peer services especially beneficial. **Families with the following characteristics or needs should also be routinely offered peer support services:**

- Families with multi-system involvement (e.g., child welfare, juvenile justice, etc.)
- Youth re-entering community and home from juvenile justice, from hospitalization for psychiatric or substance use needs, or from residential care
- Youth stepping down from a longer-term intermediate level of care (e.g., intensive in-home, extended day treatment, etc.)
- Caregivers reporting high levels of stress regarding their children's behavioral health needs (e.g., scoring high on the Caregiver Strain Questionnaire)
- Children or families who have concerns regarding engaging in treatment or who have had prior negative experiences with services
- Children and families on long wait lists
- Transitional age youth, especially those transitioning out of foster care



RECOMMENDATION 5

Implement peer support services as prevention and early intervention strategies.

Across child-serving systems, agencies have an opportunity to implement peer support services as a prevention strategy. Schools, pediatric primary care providers, early childhood programs, juvenile justice and child welfare staff, among others, should be able to make referrals to family and/or youth peer support services as a community resource to prevent or intervene early as behavioral health concerns arise. These services can be provided by certified youth and family peer support specialists employed within family-run organizations. Connecticut currently provides family peer support services for caregivers of children with a variety of needs and levels of acuity, however most funding is targeted for caregivers of youth with serious emotional disturbance.

The state should invest in expanding peer support services for more intensive levels of care and needs, and should also offer peer support to work with children (or with families of younger children) who are at risk for or have emerging behavioral health concerns at lower levels of intervention need. Such support can help children and families identify and access services earlier and potentially prevent involvement in higher levels of care or other systems.

Child-serving systems may identify youth at-risk based upon results of behavioral health screenings (e.g., substance use, depression, trauma screening), system involvement, concerning behaviors, or based upon identified challenges within family dynamics. Protocols should ensure that children with concerns that would benefit from behavioral health intervention are referred for appropriate services either at the screening or at any point during the peer support service.

In addition to the training required for the youth or family peer support specialist certification, **family and youth peers working in prevention and early intervention should receive training in single session consultation for common low-risk behavioral health concerns.**

State, federal, or private foundation grants should be sought to support this work, especially any components that are not insurance reimbursable. **Family-run organizations should receive the capacity building and infrastructure support needed to be able to directly bill Medicaid** ([see Recommendation 1](#)). It should be noted that this requires investment of resources in the initial infrastructure (e.g., training on billing, electronic health record systems, etc.).



RECOMMENDATION 6

Expand the role of individuals with lived expertise throughout the children’s behavioral health system and grow the capacity of those with lived experience to fill more leadership positions within the system.

In addition to peer support services, **Connecticut should expand the roles of individuals with lived experience throughout Connecticut’s system, inclusive of service delivery, leadership, and policymaking.**

The addition of the **Parent with Lived Expertise Consultant** position at DCF offers an example of explicitly embedding lived expertise within the system. Such a role offers benefits to the individual families they support, to the system’s understanding of families’ strengths and needs, and to the agencies’ approach to working with families. **Other agencies within the children’s behavioral health system should identify what they are currently doing to integrate lived experience within their agencies, and opportunities for strengthening this role.**

Each advisory body should develop and implement an action plan to ensure membership and participation of individuals with lived experience, including youth and family representation within leadership positions. Each advisory body should expand their reach to both youth and family members with lived experience, and work to expand representation across race and ethnicity, primary language, gender, system involvement, and behavioral health needs.

As possible, participation should be supported by compensation for time spent in meetings, child care access, language interpretation, and with consideration of days, times, and locations of meetings to maximize access and participation. Where they are not already in place, provider agencies and nonprofit partners can mirror these efforts with their own boards or advisory councils.

In addition to the need to expand youth peer support options, Connecticut has gaps in engaging youth in decision-making structures. **The state should build capacity for greater youth involvement by recruiting youth with lived expertise onto decision-making bodies.** Given the challenges that are often encountered when attempting to engage youth, including disconnections between youth and adult cultures, differences in modes of communication, transportation and scheduling barriers, legal concerns, and sometimes prior negative experiences with system engagement, it’s recommended that state receive consultation from an organization with youth engagement expertise (optimally one that is run by young adults). In addition to consultation, Connecticut should work to initiate a statewide chapter of a national youth-run organization.



RECOMMENDATION 7

Evaluate peer support services and track outcomes to support sustainability and inform gaps in research.

Many of the benefits of peer support are well documented, however gaps remain, and in particular the relationship between specific peer support roles and youth and family outcomes. **The state should include data collection for ongoing quality improvement or program evaluation** as new

family and youth peer support programs are implemented, to inform program development and ensure that funding is used to support effective services. Demonstration of outcomes, inclusive of cost savings, can also be used to obtain sustainable funding.

ACTION PLAN



ACTION STEP (RECOMMENDATION NUMBER)

POSSIBLE LEAD ENTITY/ PARTNER

FINANCING

Include Family and Youth Peer Support Specialists within DPH certification to provide DSS verification of completion of approved peer support training certification program **(1)**

DPH, DCF, family-run organizations, peer certification organizations.

Develop legislation that will appropriate funding and change state Medicaid policy to reimburse prevention and intervention services provided by peer support specialists **(1)**

CT General Assembly, TCB, CBHPIAB, DSS

Develop legislation that will appropriate funding and change state Medicaid policy to provide a bundled payment for Wraparound **(1)**

CT General Assembly, TCB, CBHPIAB, DSS

Amend the Medicaid state plan per legislation **(1)**

DSS

Fund infrastructure development for family-run organizations to directly bill Medicaid **(1, 5)**

CT General Assembly, TCB, DCF, DSS

Identify potential strategies to secure reimbursement for services provided by peer support specialists from commercial insurers **(1)**

Connecticut Insurance Department, CBHPIAB, TCB

Grants to family-run organizations to offer the training and certification at little or no cost to parents and caregivers with lived experience who are ready in their wellness or recovery journey with their child to become family peer support specialists **(2)**

CT General Assembly, TCB, DCF, other state agencies

ACTION STEP (RECOMMENDATION NUMBER)

POSSIBLE LEAD ENTITY/ PARTNER

PLANNING

Identify training opportunities for the family and youth peer support workforce that can support identified needed skills and competencies, including: peer supervision, single session consultation, juvenile justice, intellectual and developmental disabilities, LGBTQIA+ youth, and youth with co-occurring mental health and substance use needs **(2, 3)**

CBHPIAB membership, family-run organizations, peer certification organizations, families and youth

Develop or adapt tools to support implementation of peer support services, including an organizational readiness assessment, role matrix, and career pathway **(3)**

CBHPIAB membership

Build an infrastructure for youth peer support training and certification aligned with best practices **(2)**

CBHPIAB, CBHAC, youth-run organizations, peer certification organizations

State agencies within the children's behavioral health system identify what they are currently doing to integrate lived experience within their agencies, and opportunities for strengthening this role **(6)**

CBHPIAB members

Each advisory body should assess membership and participation of individuals with lived experience, including youth and family representation within leadership positions, and develop and implement an action plan as needed **(6)**

CBHPIAB, CBHAC, TCB, SAC, BHPOC, JJPOC

Build capacity for greater youth involvement by recruiting youth with lived expertise onto decision-making bodies **(6)**

CBHPIAB, CBHAC, TCB, SAC, BHPOC, JJPOC, youth-run organizations

IMPLEMENTATION

Ongoing professional development opportunities should be funded and required to maintain peer certification **(2)**

CT General Assembly, DCF, DPH, family-run organizations, peer certification organizations

As funding becomes available, prioritize those service types, youth and family needs identified in Recommendation 4, including prevention and early intervention **(4)**

CBHPIAB, DCF, DSS, other state agencies

As family and youth peer support services expand, launch an awareness campaign regarding the benefits of peer services and processes for referral, including within potential prevention referral sources (e.g., primary care, early childhood) **(5)**

CBHPIAB membership

Fund and require data collection for ongoing quality improvement and program evaluation to inform future peer support implementation **(7)**

State agencies

Appendix A:

Staff Survey; Non-licensed Behavioral Health Staff

First Name _____

Last Name _____

Email Address* _____

Are you Spanish/Hispanic/Latina/o/e? *(Select all that apply)*

- | | |
|---|--|
| ☐ No, Not Spanish/Hispanic/Latina/o/e | ☐ Yes, Dominican |
| ☐ Yes, Mexican, Mexican American, Chicana/o | ☐ Yes, Colombian |
| ☐ Yes, Puerto Rican | ☐ Yes, Other Spanish/Hispanic/Latina/o/e (specify group):
_____ |
| ☐ Yes, Cuban | _____ |
| ☐ Yes, Salvadoran | |

Please check one or more of the following groups of which you consider yourself to be a member *(Select all that apply)*

- | | |
|--|---|
| ☐ American Indian, Alaska Native, Original Peoples of the Americas | ☐ Guamanian or Chamorro |
| ☐ Asian Indian | ☐ Samoan |
| ☐ Black, African American | ☐ Native Hawaiian, Pacific Islander, Original Peoples |
| ☐ Chinese | ☐ White |
| ☐ Filipino | ☐ Hispanic, Latinx, or Spanish Origin |
| ☐ Japanese | ☐ Prefer to self-describe:

_____ |
| ☐ Korean | |
| ☐ Vietnamese | |

How would you describe your current gender identity? (Select all that apply)

- ☐ Agender
- ☐ Gender fluid
- ☐ Non-binary
- ☐ Prefer not to answer
- ☐ Cisgender
- ☐ Gender queer
- ☐ Transgender
- ☐ Gender-expansive
- ☐ Man
- ☐ Woman

☐ Prefer to self-describe:

What is your age?

- ☐ 18 to 24
- ☐ 25 to 34
- ☐ 35 to 44
- ☐ 45 to 54
- ☐ 55 to 64
- ☐ 65 to 74
- ☐ 75 or older

What type of service(s) do you regularly work with? (Select all that apply)

- ☐ In-home/home-based services
- ☐ Intensive outpatient and/or partial hospitalization
- ☐ Extended day treatment
- ☐ Inpatient psychiatric
- ☐ Residential services
- ☐ Inpatient substance use treatment
- ☐ Outpatient substance use treatment
- ☐ Mobile crisis
- ☐ Urgent crisis center
- ☐ Care coordination
- ☐ Juvenile justice
- ☐ Child welfare/child protective services
- ☐ Other - write In:

Where is your catchment or service area? (Select all that apply)

- ☐ Fairfield County
- ☐ Hartford County
- ☐ Litchfield County
- ☐ Middlesex County
- ☐ New Haven County
- ☐ New London County
- ☐ Tolland County
- ☐ Windham County
- ☐ Connecticut Statewide
- ☐ Other - write In:

We recognize that when serving children and families roles may overlap or not quite fit a single definition. Please select the role that you feel most closely matches your role based upon the following definitions.

- ☐ **Peer Support Specialists** typically leverage lived experience to provide mentorship, emotional support, advocacy, and system navigation. They focus on empowerment and relationship-building to help individuals with behavioral health challenges.
- ☐ **Youth peer support specialists** typically work directly with young people. Family peer support specialists typically support caregivers navigating systems for their children.
- ☐ **Case Managers** typically focus on service coordination, care planning, and advocacy to ensure clients receive comprehensive and continuous support across medical, behavioral health, and social service systems. Unlike peer workers, case managers do not provide direct emotional support based on lived experience but instead specialize in logistics, referrals, and long-term care planning.
- ☐ **Care Coordinators** typically work with children and families collaboratively to help facilitate integration of health, behavioral health, and social service providers as needed. Care coordinators are distinguished from case managers by bringing service providers as well as other community supports together to work collaboratively with the family toward their goals.
- ☐ **Community Health Workers** typically act as frontline public health professionals who connect communities to health resources, provide education, and address social determinants of health. Unlike case managers, CHWs often work within communities rather than in clinical settings, often serving as cultural liaisons to improve health literacy and access to care.

☐ **Other - Write In:**

IF RESPONSE IS PEER SUPPORT SPECIALIST:

Which of the following best describes your current employment status?

- | | |
|---|--|
| ☐ Employed in a paid peer support role | ☐ Not currently seeking employment |
| ☐ Employed in a paid peer-related role (not direct support (e.g., supervision, training, program coordination, advocacy). | ☐ Prefer not to answer |
| ☐ Employed, not in a peer support or peer-related role. | ☐ Other - write in: |
| ☐ Volunteer in a peer support or related role | <hr/> |
| ☐ Unemployed | <hr/> |
| | <hr/> |

Who is your employer?

What is your title?*

How many hours per week do you work on average?

What is your annual salary?

FOR EACH OF THE FOLLOWING ACTIVITIES, PLEASE RATE. USE THE 1-5 SCALE FOR EACH CATEGORY.

• How important this activity is to your role. • How frequently this activity occurs in your current role.

Activities	Importance 1 = Not Important 5 = Very Important	Frequency 1 = Never 5 = Very Often
Provide emotional support	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Share personal stories from my own experience	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Facilitate peer support groups	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Link child or family to resources	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Schedule appointments	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Set goals with family or child	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Education or skill-building to child or family	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Community outreach or education	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Home visits	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Advocate on behalf of child or family	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Encourage or teach child or family to self-advocate	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Conduct assessments (e.g., Ohio Scales)	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Conduct screenings (e.g., trauma or drug and alcohol screening)	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Crisis planning	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Crisis stabilization or support	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Treatment planning with clinical or multidisciplinary team	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Discharge planning	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Transportation of child or family	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Attending appointments with child or family	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐

If you provide education to children or families, what topics do you provide education on?

What are the common needs of the children or families you work with? (Select all that apply)

- ☐ Mental health needs
- ☐ Substance use needs
- ☐ Developmental needs
- ☐ Physical health needs
- ☐ Housing insecurity
- ☐ Food insecurity
- ☐ Educational needs
- ☐ School-related issues
- ☐ Child welfare/child protective services
- ☐ Juvenile justice
- ☐ Other - write in:

Which population(s) do you work with directly? (Select all that apply)

- ☐ Young children (5 and under)
- ☐ Children (ages 6-12)
- ☐ Teens and adolescents (ages 13-18)
- ☐ Young adults (ages 18-30)
- ☐ Adults
- ☐ Caregivers of Children with Behavioral Health Needs
- ☐ Families
- ☐ Other - write in:

How often do you work with the following members of your program’s workforce?

Your Program Workforce Members	Regularly	Occasionally	Never
Care coordinator	☐	☐	☐
Case manager	☐	☐	☐
Child’s or family’s clinician (e.g., licensed social worker, professional counselor, psychologist, etc.)	☐	☐	☐
Prescriber (e.g., psychiatrist or APRN)	☐	☐	☐
Supervisor	☐	☐	☐
Set goals with family or child	☐	☐	☐

What system and community partners do you work with as relevant for the child or family?

System and Community Partners	Regularly	Occasionally	Never
School staff	☐	☐	☐
DCF staff	☐	☐	☐
Juvenile justice	☐	☐	☐
Youth service bureau	☐	☐	☐
Primary care/medical providers	☐	☐	☐
Other behavioral health providers	☐	☐	☐

To what extent do you agree with the following statements?

	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
My role is clearly defined and distinct from clinicians and others working with the child or family.	☐	☐	☐	☐	☐	☐
My supervisor understands my role and is able to support and guide my work.	☐	☐	☐	☐	☐	☐
My role is respected by my employer on an equal level with others working with the child or family.	☐	☐	☐	☐	☐	☐
I have received the necessary training to do my job well.	☐	☐	☐	☐	☐	☐
My employer has provided information on what opportunities are available for career advancement for me and others in my role.	☐	☐	☐	☐	☐	☐
My role helps to reduce disparities in services and support a diverse population of children and families.	☐	☐	☐	☐	☐	☐

Does your agency or organization offer financial support for pursuing further education (e.g., tuition assistance, loan repayment, etc.)?

- ☐ Yes ☐ No ☐ Unsure

If yes, what do they offer?

Does your agency or organization offer certification maintenance/recertification?

- ☐ Yes ☐ No ☐ Unsure

What position does your supervisor hold within the agency?

- ☐ Peer support specialist ☐ Licensed clinician ☐ Other - write in: _____

TRAINING:

In addition to your personal experience, what type of training did you receive that has benefited you in your role?

What types of training or experience would you recommend for others working in this role?

What is the highest level of education you have completed?

- ☐ Some high school ☐ Master's degree
☐ High school diploma or GED ☐ Doctorate degree
☐ Some college ☐ Other professional degree (please specify): _____
☐ Bachelor's degree

Do you have a certification related to your role?

- ☐ Yes (please specify):* ☐ No

We recognize that when serving children and families, roles may overlap or not quite fit a single definition. Please select the role that you feel most closely matches your role based upon the following definitions.

Which certification program have you completed?

- ☐ Parent Peer Support Practice Model (FREDLA)
 - ☐ Family Peer Support Specialist (FAVOR)
 - ☐ Youth Peer Support Specialist (YMN)
 - ☐ Peer Recovery Support Certification (DMHAS)
 - ☐ National Certified Family Peer Specialist (NFFCMH)
 - ☐ Recovery Support Specialist (Advocacy Unlimited)
 - ☐ Recovery Support Specialist Training (Hartford Healthcare)
 - ☐ **Other (please specify):***
-

What do you see as the benefits of offering family and/or youth peer support services within children's behavioral health services?

Are there any population groups you feel are underserved by your program? If so, what would make peer support services more inclusive?

What successes are you experiencing in your role?

What challenges are you experiencing in your role?

What should the State of Connecticut do to expand the number of family and/or youth peer support specialists?

What should the State of Connecticut do to improve support of family and/or youth peer support specialists?

Appendix B:

Description of Non-Clinical Staff Roles

PEER SUPPORT SPECIALISTS

(Also known as recovery specialists, peer advocates, family support specialists, etc.)

Are distinguished by their use of lived experience as the foundation of their work. Peer roles are built on principles of mutuality, recovery, hope, empowerment, and non-clinical relationship-building. Youth peers work directly with young people, while family peers support caregivers navigating systems for their children.

CASE MANAGERS

Are professionals who coordinate care and services across clinical, behavioral, and social support systems. They assess client needs, develop care plans, monitor progress, and connect individuals to services such as housing, therapy, or benefits. Unlike peer support specialists, case managers are not expected to share personal experiences and generally operate within a professional-client framework.

CARE COORDINATORS

Ensure that services across providers are organized, non-duplicative, and responsive to client needs. They often use standardized assessments, help monitor medical compliance, and address barriers to treatment. While supportive, their role is not peer-based, and they typically do not provide mentorship or direct emotional support. In pediatric systems, care coordinators may work closely with families but do so from a clinical or administrative lens rather than a lived-experience perspective.

COMMUNITY HEALTH WORKERS

Act as frontline public health professionals who connect communities to health resources, provide education, and address social determinants of health. Their work is often grounded in shared cultural, linguistic, or geographic ties, and they play a key role in improving access, health literacy, and preventive care. While CHWs often share experiences related to community context or social determinants of health, they are not required to have lived experience with behavioral health recovery or parenting a child with a behavioral health condition.

Appendix C:

Core Competencies Crosswalk for Youth & Family Peer Support Specialists

This appendix shows how core competencies for family and youth peer support specialists appear across major national and state frameworks. Competencies are grouped by domain (e.g., advocacy, systems navigation, recovery-oriented practice).

Frameworks are organized by primary focus:

- General (SAMHSA; National Association of Peer Supporters [NAPS])
- Family (Family Run Executive Leadership Association [FREDLA]; National Federation of Families [NFF]; and Connecticut's Certification Manual for Family Peer Support Liaisons and Family Peer Support Specialists)
- Youth (Youth MOVE National)

A checkmark (✓) indicates that the competency is explicitly stated in that organization's framework.

Blank cells mean the listed competency is not explicitly included in that source.

Domain	Core Competency	GENERAL		FAMILY			YOUTH
		SAMHSA	NAPS	FREDLA	NFF	CT FPSS	Youth Move National
Advocacy & Empowerment	Knowledge of Laws and Rights	✓	✓	✓	✓	✓	✓
	Advocates for Peers'/Families' Needs	✓	✓	✓	✓	✓	✓
	Advocates Within Systems to Reduce Barriers			✓		✓	✓
	Develops Advocacy Plans	✓		✓			
	Teaches Self-Advocacy Skills		✓	✓	✓	✓	✓
	Promotes Systemic Advocacy/Policy Change		✓	✓	✓	✓	✓
	Promotes Youth and Family Choice		✓	✓		✓	✓
	Promotes Leadership and Advocacy	✓		✓		✓	✓
	Participates in Anti-Stigma Efforts	✓	✓	✓			

Domain	Core Competency	GENERAL		FAMILY			YOUTH
		SAMHSA	NAPS	FREDLA	NFF	CT FPSS	Youth Move National
Systems Knowledge & Navigation	Maintains Broad Resource Knowledge	✓	✓	✓	✓	✓	✓
	Assists in Resource Navigation	✓	✓	✓	✓	✓	✓
	Links Peers to Resources	✓	✓	✓	✓	✓	✓
	Supports Access to Services (I.e., Housing, Employment, Education)	✓	✓	✓		✓	✓
	Supports Youth-Specific Transitions Across Systems			✓	✓	✓	✓
	Empowers Peers to Navigate Systemic Barriers		✓	✓		✓	✓
	Promotes Understanding of Parental Rights and Responsibilities		✓	✓		✓	
	Connects Families to Informal and Formal Supports	✓		✓		✓	
Trauma-Informed	Addresses Trauma's Impact On Wellness and Recovery	✓	✓	✓			✓
	Recognizes Signs of Trauma	✓	✓	✓			✓
	Cultivates Safe Spaces	✓	✓	✓			✓
	Utilizes Strengths-Based Approaches	✓	✓	✓		✓	✓
	Develops Crisis Planning Tools	✓		✓			
Recovery-Oriented	Fosters hope	✓	✓	✓		✓	✓
	Uses recovery-oriented language	✓					
	Emphasizes choice and autonomy	✓	✓	✓		✓	✓
	Supports goal setting	✓	✓	✓		✓	
	Encourages informed decision-making	✓	✓	✓		✓	
	Models recovery through lived experience	✓	✓	✓		✓	✓
	Engages peers across the recovery continuum	✓	✓		✓		
	Triangulates credible recovery approaches from multiple sources	✓					
	Supports collaboration and teamwork	✓		✓		✓	

Domain	Core Competency	GENERAL		FAMILY			YOUTH
		SAMHSA	NAPS	FREDLA	NFF	CT FPSS	Youth Move National
Culturally Responsive	Practices cultural humility	✓	✓	✓			✓
	Values diversity	✓	✓	✓		✓	✓
	Tailored approaches	✓	✓	✓		✓	
	Developmentally appropriate	✓		✓			✓
	Recognizes intersectionality		✓		✓		✓
Person-Centered	Supports autonomy	✓	✓	✓	✓	✓	✓
	Tailors support to individual needs	✓	✓	✓	✓	✓	✓
	Strengths-focused	✓	✓	✓	✓	✓	✓
Voluntary	Ensures voluntary participation	✓	✓	✓	✓	✓	✓
	Respects withdrawal	✓	✓	✓	✓	✓	✓
Relationship-focused	Builds trust	✓	✓	✓	✓	✓	✓
	Maintains boundaries	✓	✓	✓	✓	✓	✓
	Supports mutuality		✓		✓	✓	✓
Lived Expertise	Shares lived experience/expertise	✓	✓	✓	✓	✓	✓
	Balances strategic self-disclosure	✓		✓	✓	✓	✓
Professionalism	Follows privacy & confidentiality laws	✓	✓	✓	✓	✓	✓
	Maintains positive reputation	✓		✓	✓	✓	
	Recognizes knowledge limits	✓		✓	✓	✓	✓
	Follows supervision standards	✓	✓	✓	✓	✓	✓

Appendix D:

National and State Certifications for Youth and Family Peer Support Specialists

The following table summarizes national and Connecticut-based certification programs for youth, family, and recovery-specific peer support specialists. These certifications establish standards of practice, formalize core competencies, and provide structured training pathways for individuals with lived experience to serve in professional peer roles.

Organization	Scope (National/ State)	Population Focus	Certification Title & Details	Definition of Peer Support	Core Competencies (Y/N)	Training Requirements
<u>Family-Run Executive Directors Leadership Association (FREDLA)</u>	National	Family	Parent Peer Specialist Practice Model Emphasis on strategic use of lived experience, effective support strategies, and self care.	Caregivers with lived experience who provide emotional support, system navigation, and advocacy to families of children with emotional, behavioral, or mental health challenges.	Y – <u>Core Competencies for Peer Workers in Behavioral Health Services</u>	40 hours; competency-based modules; lived caregiver experience required. 24 hours for supervisor training.
<u>FAVOR, Inc.</u>	CT	Family	<u>Connecticut Family Peer Support Specialist Certification</u> State-specific certification emphasizing lived experience, system navigation, and advocacy.	Family peer support is defined as services provided directly to families with children who face medical, mental, or behavioral health challenges.	Y – Aligned with SAMHSA, National Certified Peer Recovery Support, and National Federation of Families.	State-administered training aligned with national Family Peer Specialist standards.
<u>National Federation of Families</u>	National	Family	<u>Certified Family Peer Specialist (CFPS)</u> Professional national certification for family members; recognized in Connecticut.	A CFPS is a parent, family member, or caregiver who has or had responsibility parenting a child or as a primary caregiver for another family member experiencing mental health and/or substance use challenges. They can speak about and use their lived experience to support other families to advocate for their child's or family member's well-being, supporting them in navigating systems, and offering other necessary resources.	Y – <u>Peer Principles, Core Competencies, and Code of Ethics</u> ; Certification is in alignment with national standards set by SAMHSA and the Association for Addiction Professionals; <u>professional standard for Parent Support Providers (PSP)</u>	A parent, family member, or caregiver who has or had responsibility parenting a child or as a primary caregiver for another family member experiencing mental health and/or substance use challenges plus 88 contact hours of training, and 500 hours of work (paid or unpaid) experience delivering peer level support to other similarly situated families are eligible to apply for certification.

Organization	Scope (National/ State)	Population Focus	Certification Title & Details	Definition of Peer Support	Core Competencies (Y/N)	Training Requirements
Youth MOVE National	National	Youth	Youth Peer Support Specialist (YPS) National program focused on youth empowerment, advocacy, and strategic self-disclosure. Used by FAVOR and Advocacy Unlimited in Connecticut.	Youth peer support engages young people with lived experience to provide empowerment, recovery navigation, and leadership development.	N – No specific competencies; maintains <u>code of ethics, core values, and principles</u> .	40+ hours; youth-specific lived experience required.
Mental Health America (MHA) & National Certification Board for Behavioral Health Professionals (NCBBP)	National	Adult Substance Use	<u>National Certified Peer Specialist (NCPS)</u> <u>National Certified Peer Recovery Support Specialist (NCPRSS)</u>	Peer support is a process through which people who share common experiences or face similar challenges come together as equals to give and receive help based on the knowledge that comes through shared experience.	Y – Defined as 6 “Performance Domains” for peer specialists: 1) Foundations of Peer Support; 2) Foundations of Health Care; 3) Systems Mentoring; 4) Shared Learning, and Relationship Building; 5) Activation and Self-Management Advocacy; 6) Professional and Ethical Responsibilities	>40 hours training, 2,000 hours supervised work, and 3 letters of recommendation.
<u>Advocacy Unlimited (Recovery University)*</u>	CT	Substance Use Young Adult (18+)	<u>Recovery Support Specialist (RSS)</u> Training focused on trauma-informed care and youth/family recovery principles.	Peer support is a process driven by individuals with lived experience of mental health challenges or addiction.	Y – Covered in RSS Training	80-hour training program covers peer support, stress management, and job readiness. DCF in planning phase for possible training for peers for youth with co-occurring needs.
<u>Connecticut Community for Addiction Recovery (CCAR) Recovery Coach Academy*</u>	CT / National	Substance Use Adult Young Adult (18+)	<u>Recovery Coach Academy</u> - Nationally recognized recovery coach training model. <u>Recovery Coach Academy for Young People</u> Offers a range of recovery training modules and continuing education	Peer support provided by individuals with lived recovery experience to assist others in sustaining recovery.	Y – Covered in the <u>RCA Training</u> Also offers <u>Ethical Considerations for Recovery Coaches (CEU Course)</u>	5-day/30-hour training; focus on recovery principles and mentoring. DCF in planning phase for possible training for peers for youth with co-occurring needs.

Organization	Scope (National/ State)	Population Focus	Certification Title & Details	Definition of Peer Support	Core Competencies (Y/N)	Training Requirements
<u>Recovery Leadership Academy</u> (Hartford HealthCare)*	CT	Substance Use Adult	Recovery Support Specialist Training Training emphasizes peer-based support, recovery experiences, and behavioral health principles.	Recovery Support Specialists work in behavioral health systems across the state using their own experience with recovery to support those seeking or currently receiving treatment for mental illness or substance use.	N	80 hour course (7-week virtual training) prepares persons in recovery from a psychiatric or substance use disorder, or family members of people in recovery.
<u>Connecticut DMHAS Office of Recovery Community Affairs</u>	CT	Substance Use Young Adult (18+) Adult	Certified Peer Support & Recovery Professional (CPSRP) Certification implemented through the Connecticut Certification Board (CCB).	Young adult peer workforce embedded in recovery and crisis support services.	Y – Aligned with SAMHSA's Core Competencies	Training requirements set by CCB; includes modules on crisis support and advocacy.

*These three peer support certifications have historically been recognized by DMHAS for training and certifying peers in the DMHAS-funded adult system. Building on this strong foundation, DMHAS is launching a certification process in 2026 to align key competencies and ensure consistency in training statewide. The Certified Peer Support & Recovery Professional (CPSRP) credential will serve as the DMHAS-recognized certification for adult peer support.

Appendix E:

Connecticut Peer Support Programs and Services

FAMILY-FOCUSED: These programs provide caregiver-to-caregiver support, advocacy, and navigation of behavioral health, education, and related systems.

Program/Service	Target Audience	Supports & Services Offered	How to Access
African Caribbean American Parents of Children with Disabilities (AFCAMP)	Families of children with disabilities or at risk of system involvement	Parent advocacy; Education rights support; System navigation; Peer/family engagement	afcampa.org
Child Guidance Clinic for Central CT	Families & children	Parent peer groups	cgccentralct.org
Connecticut Family Support Network (CTFSN)	Families raising children with disabilities and special healthcare needs (including behavioral health)	Family support groups; Peer connections; Resources for behavioral health, disability, and special education	ctfsn.org
FAVOR – Family Peer Support Program	Families of children with behavioral health needs	1:1 Family Peer Support Specialists; Advocacy; Navigation of DCF, schools, juvenile justice, and behavioral health systems	favor-ct.org
NAMI Connecticut – Family Programs	Families & caregivers of youth with mental health conditions	Peer-led Family-to-Family and Basics programs; Support groups; Education and advocacy	namict.org
Rushford Center	Individuals and families	Integrated substance use and mental health treatment; Family peer support services	rushford.org
The Village for Families & Children – Parent Peer Support	Parents & caregivers navigating children's behavioral health	Peer advocacy; System navigation; Parent-to-parent support; Coaching on care planning	thevillage.org
Wheeler Clinic – Family Health & Wellness Centers	Families and children	Behavioral health services; Peer support integrated into care teams; Substance use recovery supports	wheelerclinic.org

YOUTH & YOUNG-ADULT FOCUSED: These programs connect young people with near-age peers and mentors who share lived experience to support recovery, leadership, and wellness.

Program/Service	Target Audience	Supports & Services Offered	How to Access
CT STRIDE Program	Serves a targeted group of incarcerated women, both pre- and post-release, from York Correctional Institution, Niantic, CT.	Workforce readiness; Job search/retention; Counseling; Group support; Reentry planning (housing, transportation, family reunification)	ctstate.edu/stride
CT Support Group (formerly TurningPointCT)	Teens & young adults across Connecticut	Online resource hub; 1:1 peer support (Positive Directions); SMART Recovery groups for teens; Peer group connections; Story-sharing & blogs	ctsupportgroup.org
New Haven Pride Center - PeerLink & YouthLink	LGBTQ+ youth ages 16-24 (PeerLink) and LGBTQ+ youth in foster care (YouthLink)	Peer support; Advocacy; Social connection; Educational workshops; Referrals (DCF partnership)	newhavenpridecenter.org
NAMI Connecticut - Young Adult Connection	Young adults	Peer-led support groups; Mental health education; Community connections	namict.org
Youth Link Mentoring Program (BGV, NH Pride Center, DCF)	LGBTQIA+ youth ages 13-21 (DCF referrals)	Matches youth with affirming adult mentors; Long-term supportive and advocacy relationships	bgvillage.org
Youth MOVE National - Youth Advocate Leadership Academy (YALA)	Youth & young adults (14-29) with lived/system experience	20-hour youth leadership and advocacy training; Peer-led group consults; Online curriculum	youthmovenational.org
Youth Recovery CT	Teens & young adults with substance use challenges	Peer recovery coaching; Group supports; Connections to treatment & recovery services	youthrecoveryct.org
Youth Villages - LifeSet	Transition-aged youth (foster care alumni)	Weekly 1:1 support; Housing assistance; Education & vocational support; Money management; Relationship-building	youthvillages.org

ADULT & GENERAL PEER SUPPORT*: These programs provide peer-led recovery and wellness supports primarily for adults. While they have limited roles with youth or their families roles, they play a vital part in Connecticut's peer support network and reflect recovery-oriented, person-centered best practices.

Program/Service	Target Audience	Supports & Services Offered	How to Access
Advocacy Unlimited – Recovery University	Individuals in recovery (youth, family, adults)	80-hour Recovery Support Specialist (RSS) Training & Certification; Peer Warmline; Hearing Voices Network; WRAP groups	advocacyunlimited.org
CCAR – CT Community for Addiction Recovery	Young adults and families impacted by substance use	Recovery Community Centers; Recovery Coach Academy; Young People's RCA; Telephone Recovery Support; Emergency Dept. Recovery Coaches; Corrections reentry coaching	ccar.us
Hartford HealthCare – Recovery Leadership Academy	Individuals in recovery and family members	80-hour RSS training; Peer support leadership development	hhcbehavioralhealth.org
Peer-Run Respite – The Gloria House	Adults 18+ in Connecticut	Short-term (7-day) residential peer respite; 24/7 peer staffing; 30-day follow-up outreach; Alternative to hospitalization	newlife2.org

*Please note that beginning in 2026, the state's new centralized certification will be initiated. At the time this report was written, DMHAS was in the process of determining which training programs would be approved for inclusion.

ENDNOTES

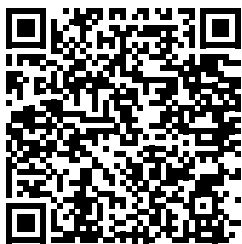
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The **Child Health and Development Institute** provides a bridge to better behavioral health and well-being for children, youth, and families. We collaborate with policymakers, providers, schools, and partners to advance system, practice, and policy solutions that result in equitable and optimal outcomes in Connecticut and beyond.