# Peer Workforce Development

## Summary of Listening Sessions

December 2022

## *Background*

In January 2021, the Pennsylvania Department of Drug and Alcohol Programs (DDAP) launched *Recovery Rising* to foster a resilient, diverse, and accessible recovery environment in Pennsylvania. *Recovery Rising* convened stakeholders over five months to develop trust, facilitate learning and information exchange, define common ground and shared values, build collective commitments, and identify shared priorities and items for action. These stakeholders engaged in one-on-one conversations, facilitated regional meetings, and participated in a statewide event to deepen their understanding of community needs, evidence-based approaches, and person-centered strategies. Information gathered from these events was organized into eight broad categories:

1. Creating Equitable, Sustainable, and Flexible Funding for Recovery Supports
2. Building the Capacity and Expanding the Role of Recovery Community Organizations
3. Making a Commitment to Ensure Diversity, Equity, and Inclusion
4. Making Person-Centered and Recovery-Oriented Care the Norm
5. Providing the Critical Recovery Support Services Needed in Pennsylvania
6. Improving Access in Rural Areas
7. Providing Education and Training to Reduce Discrimination and Equipping People to Support All Pathways to Recovery
8. Building State Infrastructure to Support Recovery

DDAP recognizes that elevating the voices of people in recovery in informing and making decisions positively impacts all categories. DDAP sought to understand and remove barriers for people wanting to access recovery support services, individuals seeking certification, and organizations seeking funding to sustain peer supports. DDAP also wished to identify best practices to quantify the value of and replicate peer support.

## *Method*

DDAP contracted with C4 Innovations (C4) to conduct a series of four virtual listening sessions comprised of stakeholders with insight to the peer recovery workforce, including certified recovery support specialists, program directors, people with lived and living experience of recovery, and leaders from single county authorities (SCAs). A total of 47 people were invited and 28 people accepted invitations and attended the sessions. (See full list under **Appendix B**.) Those attendees represented the following 17 counties: Allegheny, Armstrong, Berks, Blair, Bucks, Clearfield, Columbia, Dauphin, Franklin, Jefferson, Lancaster, Lebanon, Lehigh, Monroe, Philadelphia, Westmoreland, and York. Listening session participants were compensated for their time.

The listening sessions were conducted in October 2022. Four dates and times were offered and people who accepted C4's invitation then selected a date that worked best for them. Therefore, each session was a self-selected mix of individuals. Participants were asked

questions related to 1) best practices in peer supervision, 2) barriers for Black, Indigenous, and People of Color (BIPOC) to pursue recovery support specialist certification or lead organizations that receive funding to provide recovery support, 3) models and practices for peer support service delivery to replicate, 4) status of peers working within recovery-oriented systems of care (ROSC), and 5) quantifying the unique contributions of peers.

C4 prepared discussion protocols, facilitated the four listening sessions, and used a team-based approach to analyze the qualitative data drawn from these discussions. During this analysis, C4 categorized the data into key findings by thematic areas. These findings and selected representative quotes are summarized in this report.

## *Summary*

Across the four listening sessions, participants represented a mix of individuals from 17 of the 67 counties in Pennsylvania. Each session was highly interactive, with participants eager to share their feedback with each other as well as with the facilitators. Attendees found significant common ground while also pointing out strengths and gaps in specific counties. Overall, the discussion ranged from peer supervision and training to workforce development, equity and cultural responsiveness, stigma, value and outcomes of peer support, financing, and integrated models.

Attendees discussed the importance of supervision delivered by skilled peer supervisors, as a priority for supporting the development of the peer workforce. With formal training, supervisors are better able to define the peer role, know the history of and rationale for peer support, and value the non-clinical perspective peers add to teams. Participants identified concrete ways that people supervising peers could be trained to increase effectiveness in their roles. For example, organizations employing peers may need incentives such as funds earmarked for supervisor trainings in order to prioritize supervisor training in general and specifically for peer staff in supervisory roles. Additionally, in order to support peer-to-peer learning among supervisors, DDAP might consider sponsoring facilitated "supervisor support groups" where anyone who is supervising peer services can attend and share ideas with others. Attendees also noted challenges associated with moving from a peer role to a more advanced position in the field, emphasizing the importance of including professional development as part of ongoing supervision and equipping supervisors to do this well.

The groups also identified areas that may pose barriers to developing the peer workforce. One is the certified peer application process; ideas for streamlining include using plain language in the application and reducing elements in the process that create barriers to broader workforce recruitment, especially among BIPOC individuals. Additionally, there remains a lack of awareness of certified peer job opportunities among BIPOC communities, indicating that current outreach methods are not effective. Attendees also suggested changes to the certification training curriculum, which could help to better prepare peers for success in their roles. For example, peers and program directors both noted that the volume of documentation

required of peers is burdensome but necessary, and peers do not necessarily come into the role with this skill. They suggested adding documentation skills to the formal peer certification courses.

In addition to workforce barriers, there are also barriers to making peer services more consistently available in BIPOC communities. This is due in part to how peer recovery support services are typically allocated to community-based organizations. For example, some BIPOC individuals would prefer to receive services from programs other than those run by established recovery community organizations. Seeking out areas of alignment between faith-based and other grassroots community-based organizations that are or could be providing fundable, culturally responsive recovery support services in local communities may help raise awareness of services available and of professional peer job opportunities.

Across all communities, stigma is a persistent barrier to peer-based and other recovery supports. Attendees noted that stigma can negatively impact treatment and recovery initiation. A public education campaign to further pro-recovery and anti-stigma awareness could be targeted to underserved areas and serve as a resource to further understanding about substance use, mental health, and recovery overall as well as specific resources and access pathways that are currently available.

Part of growing peer support statewide is recognizing and demonstrating the tremendous value of peers in the recovery process. Attendees reiterated that the presence of peers in the behavioral health system has improved individual outcomes and helped providers better understand both the peer role and patients seeking recovery in health care and prison/jail settings. They also noted that services remain limited in criminal justice settings but play a critical role in initiating recovery and diverting people from incarceration.

One group discussed the importance of evaluating the short- and long-term impacts of peer supports by using measures of recovery success, rather than treatment completion, which is often centered in outcome evaluations. Attendees suggested that DDAP consider what data are used to quantify the full value of peer support for individuals, their families, and communities; engage people in recovery to identify and prioritize these measures; and pilot test a set of recovery measures over time to gather feedback.

Another key aspect of growing and sustaining peer services is financing. Respondents were clear that they desire alternatives to a reimbursement model that relies on fixed-price time increments. They prefer a more holistic and flexible service that can be individualized to meet client needs rather than pre-defined service options and timeframes. DDAP may want to engage peer service providers to help define parameters and benchmarks that could be used as an alternative to current financing structures and explore pathways to improving payment rates overall so that peer roles pay a competitive, living wage.

Attendees offered insights about promising models for integrating peer roles with other services. For example, the model of pairing peers with case managers is a strong example of

offering integrated services while preserving the uniqueness of the peer role. DDAP may want to identify, document, and disseminate models that successfully integrate peer roles with other services to educate other agencies on a structure for roles, collaboration, and funding.

The activities and influence of Single County Authorities (SCAs) were raised in every session. The SCAs were established to develop and expand community-based drug and alcohol prevention, intervention, and treatment services that are targeted and customized to the needs of the local communities rather than having the state decide a universal approach to SUD service delivery to be used in all counties. The SCAs are relevant as nodes and allies in the *Recovery Rising* effort going forward, and in advancing the equitable development of the peer workforce.

## ***Detailed Findings***

Findings from the focus group discussions are described below and organized around five key themes as well as multiple sub-themes. Primary themes include: 1) best practices in peer supervision, 2) barriers for Black, Indigenous, and People of Color (BIPOC) to pursue recovery support specialist certification or lead organizations that receive funding to provide recovery support, 3) models and practices to replicate for peer support service delivery, 4) status of peers working within recovery-oriented systems of care (ROSC), and 5) quantifying the unique contributions of peers.

See **Appendix A** for feedback related to on-the-job training for people in peer roles, including length of time in personal recovery prior to starting a peer role.

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### 1) Best Practices in Peer Supervision

Respondents identified critical infrastructure, practices, training, and competencies needed to best supervise and support peer workforce growth.

<u>Access to trained supervisors in recovery</u>. A majority of attendees prefer supervision from people in long-term recovery and with experience in the supervision of peers. They felt the lived experience component of recovery cannot be trained and is more important than other professional degrees as it relates to the supervision of peers. If a supervisor is not in recovery, the supervisor should receive mentoring from someone who is, to understand and support the uniqueness of the peer role, or a co-supervision model should be considered. Too often, supervision delivered to peers is focused on meeting job requirements and not on being a person in recovery working in this field.

> *"I get supervision in terms of what my job is, but not in terms of a man in recovery working in this field. So, I pay someone else to supervise me biweekly."*

Structured supervision is conducted intentionally and regularly. Supervision that is scheduled, consistent, routine, and both administrative and supportive is needed by peers. Attendees recommended using a "supervision sheet" to maintain clarity and direction, but also shared that informal conversations that happen before and after supervision are important. Supervision can be organized around four quadrants "1) policy and procedures, 2) role clarity, 3) professional development, 4) self-care (most important)." Attendees also shared that organizations need to value supervision as a whole and put a high level of commitment towards supervision.

Supervision includes professional development. Supervisors should inform staff about available trainings related to the peer role and other professional skills. Peers juggle a variety of responsibilities and benefit from broadening their knowledge. Supervisors should not assume that the peer will always want to stay in a peer role and should be encouraging if peers ask about training and growth opportunities.

> *"People don't ever see you as being more than a peer. You have to go back to school and get degrees. But really, I prefer to lead with my lived experience (rather) than with my degrees."*

Supervisors teach documentation skills. Attendees shared that group supervision (where everyone reviews cases, case notes, and documentation together) is great for professional development and skill-building. Also, there are many "gray areas" on how to support folks and learning from experienced team members in a group setting helps. Correct documentation and managing your time, to include space for documentation, are skills that peers need.

> *"I've taken trainings where everything in the training about boundaries is very black and white. Where I am, we have put some gray areas in. We added case studies of stuff that we've gone through, that you couldn't make up! Some of the situations are 'out there', but they're all real, they happened."*

Supervisors explain limits of a peer role. Supervisors can help peers avoid getting buried in paperwork and compassion fatigue by teaching them to pace themselves and set realistic expectations for what can be accomplished. For some, the peer role is their first or most recent professional job and they want to "do it all" and impress their supervisors, which can lead to feeling overwhelmed. Also, it is important to differentiate between Certified Recovery Specialist (CRS) and Certified Peer Specialist (CPS) roles and expectations, as they tend to be different.

> *"I worry about people new to field, wearing 'recovery superhero capes' because they want to save everybody. I very much worry about them because that's not what we're here to do, and it's not very realistic."*

Supervisors understand the necessity of self-care. It is critical for peers to be encouraged to maintain their self-care and to feel that they can maintain a boundary between their personal and professional lives. One attendee noted that if you have an "addictive personality" it can transfer to becoming a "workaholic." This may mean not knowing when to stop, and having difficulty keeping boundaries between work and off hours. Related, supervisors should not require or allow peers to use their personal phones for work. Some peers incur challenges to self-care and maintaining their preferred recovery pathway, not only due to overwhelming workloads. For example, a peer worker may prefer 12-step meetings but live in a small community where they do not want to encounter their clients at the meetings. Self-care helps peers stay in the field longer and should be supported via supervision, which can involve some strategizing and problem-solving about barriers.

> *"For those of us who have the lived experience, a lack of self-care could end us, could end up me getting high again. Now, for someone that doesn't have lived experience, maybe their repercussion would be they overreact or something like that. But for us, it's really, life or death. And this has to flow from the top down.... Because you could tell me that I need to take care of myself, but if I got to answer my phone, my own personal phone 24/7, what message are you sending me?"*

Supervisors model boundaries. Supervisors without experience working as a peer may not know the specific type of boundaries that peers need to fully understand and be able to navigate. There are work-life balance type boundaries, and service delivery boundaries that are different than a clinician's or a case manager's boundaries.

Agencies support peer supervisors. Attendees recommended more supervisor development trainings for supervisors. One person worked for a year as a supervisor to become certified as a peer supervisor, which to them seemed like a long time. Supervisors and directors also need their own regular supervision. In one case a director pays a person outside of her agency for supervision.

> *"When you become a supervisor to peers, I think there is a lot of missing supervision there as well. I was a certified peer specialist for six years and then I got a job as a supervisor and they put me in a little training, lasted about two days, and then they stuck me in the role. I was constantly getting reprimanded for crossing boundaries. But you figure for six years I've been told to cross these boundaries. I've been told to use my lived experience, I've been told to do these things, but now I'm not supposed to. But I am, but I'm not. I wasn't given the kind of supervision that I needed to be productive in that role."*

Agencies have diversity among supervisors. Gender identity, race, and ethnicity can all impact the supervisory relationship. Attendees recommended that agencies employ staff members of various genders (in addition to staff of various races and ethnicities) to work as supervisors. Peers who want to discuss some personal recovery struggles with their supervisor may feel awkward if their supervisor is of a different gender identity.

## 2) Barriers for Black, Indigenous, and People of Color (BIPOC) to pursue recovery support specialist certification or lead organizations that receive funding to provide recovery support

Respondents summarized individual- and systems-level challenges for BIPOC individuals to pursue peer certification, as well as BIPOC individuals seeking or receiving recovery support.

Stigma around addiction. Attendees shared that there is stigma towards addiction within the Black community. Attendees also shared that Black people are reluctant to talk about suffering with any kind of disorders, which may stem from historical mistreatment in medical systems.

Certification application process is difficult. The application form and process are complex and could be in more plain language. This may increase the applicant pool. A peer may need employer support to get everything together to submit an application.

Not many BIPOC folks already in peer and other prominent roles. More BIPOC people may pursue peer work if they see other people of color already working as peers. The City of Philadelphia has done a lot to hire people of color into prominent and public facing roles, but it has not been enough. One person noted that while his organization has several Black women working as peers, they also need Black men as peers. Sometimes clients want someone of the same race and gender as them to deliver their services.

> *"People are successful in recovery when they get hope from somebody that maybe they can recover. It's powerful when that hope comes from somebody that looks like me. Same thing with becoming a peer – I meet someone like me doing CRS work, and I think, I can do it too."*

> *"As a Black woman I am not going to say that I get more respect, but I get a certain level of respect from the peers that I work with because I look like them. And I think that's the peer... I think that's peer culture in a nutshell. 'Hey, look at you, Black woman. You're doing your thing. You're in recovery. You've got mental health concerns. You dealt with drugs and alcohol and yet and still you're here trying to help me save my life. And that's amazing.' That's what peer culture is all about."*

Pay rates are not satisfactory for level of work. Attendees expressed that it takes a lot just to become a CRS – 78 credit hours and a lot of documentation – and the pay is not very high. Job satisfaction from making a difference in the lives of others is strong, but the need for more income pushes people out.

> *"In general, the peer role needs to pay more. If I can get paid more at the grocery store, I'm going to work at the grocery store. And when you're a few years into recovery, you are shooting for bigger things."*

Hiring process expects professional capacity right from the first day. Attendees noted that some hiring practices exclude peers who may come with less skills upfront or less prepared for the job market, but they are still interested. This is a barrier to expanding the peer workforce.

More diversion programming that directs towards employment/training and not jail. Attendees recognized structural racism in jail settings and the importance of intentionally developing equitable opportunities for BIPOC folks to become engaged with peer work.

> *"I was in jail numerous times. And then I was afforded the opportunity to explore peer support. I see people of color, where I'm from, in my area, are not being provided the same opportunities as the dominant culture. We have to be intentional about creating opportunities. They are not going to happen organically."*

BIPOC community is sensitive to persistent, systemic racism. There are systemic and historical forms of racism that have improved but are still very present. Organizations, government agencies, and individuals need to continue diversifying organizations, boards of directors, etc. Also, when peers and providers come from different cultures and don't understand each other, this creates a "fear factor" and then both sides put in minimal effort. Organizations need to proactively consider the 'fear factor' as part of Diversity, Equity and Inclusion (DEI) transformation initiatives.

RCOs are not always the preferred solution for BIPOC folks to receive services. In some communities, BIPOC folks want to get their services from church or community-based organizations, not a recovery community organization (RCO). Attendees felt a church should be as able to access DDAP and PA funds as an RCO if they are delivering recovery supports; this is also a way of meeting the needs differently in different communities.

Not enough BIPOC-led organizations in the recovery space. Attendees felt it is best not to redirect resources, ideas, and people away from RCOs and into treatment programs. The groups noted BIPOC-run organizations have not been funded well and expressed their hope for DDAP to be more transparent about the reasons why BIPOC-led organizations that applied for funds in the past were not awarded. Attendees shared that this could help BIPOC applicants be more competitive in the future. They also expressed the need for a range of BIPOC peer service providers. Language is just one part of culture. People can speak Spanish but be from different places (Mexico, Puerto Rico, South America, etc.) and thus their experiences and cultures are different.

> *"Grants are 'not accessible' in BIPOC communities. You see other grassroots orgs in other counties pop up. Directors of programs that are Black and Brown, they don't understand how SAMHSA and NIDA work and how to get the money."*

## 3) Models and Practices for Peer Support Service Delivery to Replicate

Respondents summarized both specific locations where co-located peer support works well, as well as general best practices for funding, flexibility, and structure of peer service delivery.

Peer support works well where more, smaller RCOs operate. Peer support is working well in the grassroots RCOs. Attendees suggested putting the money back in the pockets of the grassroots agencies and not in "the bureaucracy." They also expressed their hope that DDAP would increase support of RCOs who have advocated for change in this sphere for the last 25 or 30 years. Peer services work well within peer-run, peer-governed organizations where recovery comes from the top down.

Peer support works well where funding is more flexible and allows different methods to deliver services. Peers working through Single County Authorities can provide services in different locations and circumstances and it's all covered. This flexibility works well. When possible, non-billable peer support should be billable and with fewer limits set up by funders. Peer supports must be delivered in the quantity and frequency that clients need, not capped per month or week arbitrarily by the funder. Attendees felt grant funding does a better job of this than Medicaid.

> *"As the program director of a recovery center, I have provided so much indirect recovery support to people coming in wherever they're at or whatever is going on. Getting people where they need to go and providing that. None of that's necessarily noteworthy or we're not billing for units or anything like that. But it's still huge."*

Peer support works well when caseloads are not influenced by funding. Attendees acknowledge the difficulties of working in funded positions that are based on fee-for-service structures or 15-minute increments of time.

> *"What is NOT sustainable is having caseloads of 120+ people, because only certain types of interactions can be billed."*

> *"My co-workers had to chase units, and they were miserable. So, on your Thursday afternoon or Friday where those CRSs have to get 50 or 60 units, all they're doing is just chasing units on Friday – making phone calls, offering to transport individuals because their supervisor or other individuals are like, 'Hey, you're not meeting the minimum requirement in your units to justify your position.' Potentially, impacting whether they're going to continue to be employed and everything."*

Peer support services are helping the criminal justice system. Attendees shared that the criminal justice system is overloaded, with probation officers doing the best they can, and that peers make a difference. When peers are involved, they bridge people better during reentry. One person noted that peers should not work in court, as they are then mandated to report

more information, rather than being a peer confidant to a person needing services. He would like to see services provided outside of the court and not paid for by the court.

Peer support services work well in hospital settings. In emergency departments (EDs) and in hospitals in general – patients are engaging and getting connected to treatment. Peers are picking up patients' needs when ED staff are stretched thin. Healthcare providers have experienced a culture shift, become more understanding of recovery, and are making more successful referrals to treatment even outside of the times when a CRS is on site. Attendees noted that similar effects have been observed in other healthcare environments.

> *"Additionally, warm handoff programs in EDs are getting patients who come in who did something illegal and agree to treatment handed off to a peer to navigate treatment options instead of going to jail. This helps people get necessary recovery support, which they won't get in prison."*

Peer services are hard to roll out in some areas due to stigma and lack of education. It is difficult to replicate good services in new areas if locals are "unreceptive" and/or not educated about substance use disorder (SUD) and mental health disorders (MH). Too much stigma and not enough education cause a disconnect for people who don't know the benefit of peer support or understand the processes taking place when someone is struggling with SUD or MH disorders.

Focusing on client outcomes and not profits supports the peer role. Job expectations need to be clearly spelled out and preferably not changed due to how insurance pays. Peer support works best when it is community-driven, person-centered, and independently funded. There is concern that people with lived experience are not "at the table" enough, and decisions are being made increasingly on a business basis, because it is becoming more and more clear that peer support is so beneficial.

> *"On one hand you have a tremendous influx of people that came into our system of care that are doing work in a variety of diverse ways and it's really peer support. Because if I'm working in a doctor's office and my job is to do intakes, okay, and I'm working with people in recovery, I can do informal peer support and do my job at the same time. The thing is that now I'm afraid people are stopping because we want to put an emphasis on peer support. People are not willing to fund that role any longer. And that makes me worried a lot because we're the experts on a lot of stuff and I don't know, case management and peer support are different. ... I'm sort of seeing at least in Lancaster swinging the other way, away from peer support more and more."*

Peer supports works well when involving family is part of the care. Peer support works better when it takes the family into account. Many times, it is disjointed, and programs don't see the synergies that exist between individuals and families.

**Peer support works well when it is elective and not mandated.** Peer supports mandated by a court may not work as well because that gets away from the restorative spirit of peer support.

**Peer support works well when embedded with case management.** Something that works well and could be replicated is how a recovery support team is embedded with a case management team. This offers both types of services, while keeping the peer roles distinct.

> *"At our hospital location, there are both a peer and a case manager. Peer works at the front end to engage; case manager completes it all by bridging to resources and fulfilling warm handoffs."*

## 4) Status of Peers Working Within Recovery-Oriented Systems of Care (ROSC)

To understand how peers have been deployed within ROSC, attendees were asked about the status of the integration of peers. Below are strengths and gaps identified by attendees.

Strength – "Cap Five" County area

"Lancaster County is great. In the cap five really – Dauphin, Lancaster, Lebanon, York, Cumberland, even Berks County, Lancaster specifically... We have an amazing recovery community and Recovery-Oriented System of Care that just continues to grow and be more collaborative. There are still gaps here and there, but I work within a community where all stakeholders partners are willing to engage in addressing any gaps in services."

Strength – Five Counties area

"We're the five counties, I'm out in Chester County. But Delaware County, Montgomery County, Berks, Philadelphia, they do have peers across their ROSCs as well. And in fact, a lot of times I even see a collaboration in between the counties."

Strength – Allegheny County

"In Alleghany County ... I take people to Mercy [Hospital], I know people in recovery that work there. I take people to treatment, and it's all filled with people in recovery. A close friend of mine who's been in recovery for 30 years is a clinical director of a treatment facility ... In Allegheny, we have a super strong recovery community, a lot of organizations that were formed by people in recovery, and they employ recovering addicts and peers and people in recovery."

Gap – Lack of communication when changes are made to local peer services

There is a need for communication from the SCAs, particularly when they are going to make some changes in how they move forward, so they do not surprise peers who are already in the field doing the work. One example given included peers being dispatched to a setting with only one peer currently working there. The person shared he was the lone PRS until that happened and he was not expecting the additional peers and had no

information about how the peers were integrating into the recovery support service he was delivering.

Gap – Need more mobile peer services
There is a need for company vehicles so a CRS can get into their communities and occasionally transport people to necessary services in the company vehicles. Peers can catch more people at risk of readmission to the hospital by outreaching directly in their neighborhood.

Gap – Criminal justice system
Getting permission to go into the prison system to provide peer services is difficult. Also, CRS services are not fully funded, so that holds back how and where services are made available.

## 5) Quantifying the Unique Contributions of Peers

Respondents discussed capturing the impact of peer support using measures of success in recovery vs. measures of treatment compliance, and summarized ideas to demonstrate the value of peer contributions to potential funders.

**Peers build recovery capital which should be assessed and measured to demonstrate value.**
Peers increase hope. One person noted her increased sense of hope helped her to be successful in recovery, and that has positively affected her children as well. Programs can be encouraged to use recovery capital assessments and set goals to increase capacity in this area. When individuals have increased recovery capital, they decrease dependence on public services supporting them, resulting in better outcomes related to SUD, and fewer admissions for services.

> *"Can you quantify recovery capital? Well, sure. I start seeing a client and she's in a women's shelter for abused women. And her kids are at CYS. And then a year later, I see her in an event with all her kids with her, she's got a house and she's living with these kids. She's got them all back, healthy looking. She needed housing, she needed help with parenting. And these are all programs that as a CRS, I was able to connect her with. So yeah, there's a way to measure it, look at the client."*

**Measure treatment engagement outcomes related to peer service involvement.** Within health care, attendees suggested looking at differences in outcomes for patients who engaged with peers vs. those who did not. Some points of measure could be:

- How many contacts were made with patients, and by what percent has that increased since a period of time without peer services involved?
- How are ED readmission rates for patients who have engaged with peers?
- How much of a percentage increase do you see in people who accepted treatment?
- What percentage of people who accepted treatment made it to their first treatment appointment?

- How many people were initially engaged in peer services? And what percent were retained in services?

Some warm-handoff/peer programs may start as an unbillable service and, with good numbers, can convert into a fundable or billable service. Outcomes can improve not just for behavioral health, but physical health as well. Evaluators could also look at patient satisfaction data and connect that back to whether satisfaction is higher when peers are involved.

<u>Move away from quantifying recovery success in terms of treatment.</u> Attendees expressed the importance of quantifying success in recovery using recovery-specific measures.

> *"I would like to just dismantle that whole question. I think recovery is the ultimate outcome. Recovery is what everybody wants, including treatment. That's why you have major treatment organizations like Recovery Centers of America calling themselves recovery instead of treatment. But the funding system that we're talking about was built for treatment. As long as we are trying to fund recovery with a system that was built to fund treatment, the question that you asked really is, tell me the treatment outcome. And I don't mean to put words in your mouth, but what it sounds like is tell me the treatment outcomes that are going to cause these funders to want to fund recovery support services."*

<u>Utilize recovery metrics to measure recovery success</u>. CRSs help individuals develop wellness or recovery plans that go beyond treatment choices and also ensure that basic needs are being met. Recovery metrics should be included to measure impact of CRSs, and to appreciate long-term recovery outcomes.

> *"We need to start using recovery metrics to evaluate recovery services and the advocacy and impact and outcomes of recovery services ... There's a lot of data collection around recovery support outcomes that're based in social determinants of health and things that are a little bit beyond treatment outcomes, just by necessity. Because if you're looking at five-year recovery outcomes, that's way beyond treatment. Treatment happened, stopped a long time ago."*

> *"We need to increase that scope of outcome measurement to include long-term recovery outcomes using recovery data and recovery measurements and then stop trying to define this within the treatment system, because it's just not sufficient to account for what we're talking about."*

<u>Measure reduced criminal justice recidivism related to peer support involvement.</u> Peers working in community-based settings are working with returning citizens. Attendees suggested measuring the number of those individuals on a caseload that were sanctioned or returned to state prison versus those folks that successfully finished off their sentence as one potential measure.

Learn to measure recovery more broadly as replacing drug use with ANYTHING, not just treatment. It can be difficult to quantify how recovery can be anything you replace your drug use with, but attendees suggested it as a possible measure. Some people develop new hobbies, and it is hard to quantify the value of that new hobby keeping people away from substance use.

Measure the qualitative difference peers make utilizing their lived experience. The capacity at which a CRS works with an individual is very different from clinicians and therapists. Peers work flexibly with clients and follow different boundaries and ethics.

> *"What's unique about a peer? Well, we have the lived experience. And it's not to say that the other addiction professionals who are maybe working with that individual don't have lived experience, but they're working in a capacity where self-disclosure is not really a thing. So, you have a peer working in a peer capacity, so self-disclosure is the thing. We are connecting with this individual in a way that nobody else has been able to connect with them. And we know, we've seen, data has shown that this can be very effective."*

> *"I've been at board meetings and people with research data experience tell me that their data outweighs my lived experience. Someone has a degree, a higher level of education, they think we are not on the same level. But we are when it comes to this."*

Create clear job descriptions to outline the responsibilities covered by peers. Peers need to have formal job descriptions both for their own clarity and so others understand and take the role "seriously". Conducting quarterly reviews with peers, even if the role is unpaid, shows funders of the organization how important the organization takes the peer role. Also, it is important to note that peer staff work in many different settings (recovery community center, county jail, ED) – each requiring additional skill sets, levels of professionalism, different assets, etc. in addition to the minimum set of standards.

Leverage data and studies to show overall cost savings. Attendees suggested the importance of demonstrating that for every dollar invested, X dollars were saved down the road, whether it be in legal, medical, community cost, social services, etc. This may require more documentation or paperwork to have the information available to parse.

> *"I know for Medicaid and the reinvestment that we did for recovery support services, and CRS services several years ago, the data that was collected from that, the MCO down here said it was the most successful reinvestment that they did."*

## Appendix A: Supplemental Feedback Pertaining to Peers Working in Peer Roles

During our sessions, attendees offered feedback related to requirements on those who apply for peer roles, and supports that peers need on the job in addition to good supervision.

Agencies require people to be in recovery a few years before starting a peer role. Attendees recommended requiring a certain minimum years of recovery before being hired. People in early recovery may still be dealing with losses and experiencing some grief, and it is important that the peer has enough time in recovery to gain perspective on how best to use their experience in service to others. It is also important to have a minimum number of years in recovery to allow a person to get better at setting boundaries with him/her/themself and with people they work with. A minimum number of years of recovery also provides additional time for a person to develop a good support system and having self-awareness around importance of self-care when feeling overwhelmed.

Suggestions for on-the-job training for peers

- Teach documentation skills (what's required for Medicaid, etc.)
- Case Managers supervising CRS staff can help teach documentation.
- Training for volunteer peers include discussion of healthy boundaries.
- Set up mentor/mentee relationships between new and more experienced CRSs and have new people supported as mentors for 1-2 years before they mentor others.
- Do 90-day assessments of new peers to check in, set new goals. Have they received certification yet? How have they matured as peers?
- Understanding that losing a "former life" of drug use may involve a mourning process as it includes the loss of a subculture of addiction, which may also have included belonging to a community.

## Appendix B – List of Participants

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| Adam Beers | Director of Operations, Sage's Army<br>Westmoreland County |
| Adam Sledd | Recovery Support Services Director, Unity Recovery<br>Philadelphia County |
| Aleisha Albertson | Assistant Director, Blair County Drug & Alcohol Program<br>Blair County |
| Andre Reid | Founder, Philadelphia NAMA<br>Philadelphia County |
| James Eagler | Single County Authority (SCA) Administrator, Franklin/Fulton SCA<br>Franklin County |
| Jared Lutz | Certified Recovery Specialist, RASE Project<br>Dauphin County |
| Jason Rilogio | REC Coordinator, Pennsylvania Peer Support Coalition<br>Lancaster County |
| Jason Simpson | Certified Recovery Specialist, P.O.W.E.R.<br>Allegheny County |
| Jennifer Henry | Certified Recovery Specialist, Clearfield-Jefferson Drug and Alcohol Commission<br>Clearfield and Jefferson Counties |
| John Carlson | Executive Director, Transformation to Recovery<br>Philadelphia County |
| Katrin Fieser | Associate Training Coordinator, Pitt PERU<br>Allegheny County |
| Martha King | Owner, Five Pillars Health Coaching LLC<br>York County |
| Mike Krafick | Certified Recovery Specialist Supervisor, AICDAC,<br>Armstrong County |
| Olivia Grace Oden | Certified Recovery Specialist, United in Recovery<br>Columbia County |

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| Rebecca Moyer | Certified Recovery Specialist, Blueprints for Addiction Recovery<br>Lancaster County |
| Rhonda Miller | Executive Director, Oasis Community Center<br>Lehigh County |
| Robert Diaz | President/CEO, Walk it Out Recovery Services<br>Bucks County |
| Robert Strauber | Director of Intervention, Recovery Centers of America<br>Berks County |
| Samuel Albert | Executive Director, Habitats of Hope<br>Lebanon County |
| Scott Theurer | Recovery Advocate, R3 House<br>Lancaster County |
| Shasta Wilkinson | Certified Recovery Specialist, AICDAC<br>Armstrong County |
| Stacy Emminger | Executive Director, Dongeal Substance Abuse Alliance<br>Lancaster County |
| Stanley Lewandowski | Certified Recovery Specialist, Monroe County SCA,<br>Monroe County |
| VonZell Wade | Founder and Director, Lost Dreams Awakening<br>Westmoreland County |
| Yvette Thomas | Certified Recovery Specialist<br>Philadelphia County |

**Recovery Rising Advisory Commission Members/Participants**

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|---|---|
| Robin Horston Spencer | RRAC Member, CRS & Former Executive Director |
| Gloria Gallagher | RRAC Member, DDAP |
| David Loveland | RRAC Member, Senior Program Director, Community Care Behavioral Health Organization |