Questions Asked During Live Webinar Broadcast on 3/27/2020

Peer Recovery Support Series, Section I: Building a Successful Culture in Your Organization

Presenters: Kris Kelly, BS/ Jenna Neasbitt, MS, LCDC, MAT-R/Philander E. Moore, Sr., MA, LCDC

1. **How do you recommend using peers in the jail setting?**
   A: Offering in-person peer support prior to release has proven to have great success. Partnering a Peer Recovery Support provider(s) with Reentry Planners is a great place to start within a jail or prison. It is helpful when PRS providers can get additional training in Forensic Peer Support. Peerstar (https://www.peerstarllc.com/) is a great example of a PRS reentry program.

2. **Kris stated that a company was good to help set up policy and procedures for peer support services. What was that company/link?**
   A: I believe I mentioned connecting with your local Recovery Community Organization or Recovery Community Center (your local RCO can be located by going here: https://facesandvoicesofrecovery.org/arco/arco-members-on-the-map/). RCO’s are experts in Peer Recovery Support Services and frequently offer consultation on considerations for PRS specific policy and procedures.

3. **Could you speak to using peers in hospital settings? Are you familiar with instances/examples where this type of peer model is used and what that may look like?**
   A: Anchor ED in RI is one of the oldest and leading model, and there are webinars with ATTC and ORN describing Anchor ED. https://providencecenter.org/services/crisis-emergency-care/anchored

4. **We have a great team of peer supporters and many good things in our programming. But we are often treated as paid sponsors and taxi service. How can those of us on the ground level implement these changes for those up the chain of command?**
   A: This is a paradigm shift that requires a perspective for change management. Kris referenced the Peer Support Toolkit out of Philadelphia https://dbhids.org/peer-support-toolkit/ And module one discusses preparing the organizational culture. This can be adapted to help you shift the norms of those who are not understanding the peer worker role in the community.

   One way to empower your peer workforce in the community, and provide a forum for educating others on the appropriate use of peers, is to have them co-lead the creation of a ROSC, with the support of your agency. Of course they don’t have to be responsible for sustaining it, because a ROSC should be self-sustaining. There is information about ROSC in the toolkit referenced. If you already have a ROSC, ensure your peers are attending and participating in work groups.

   Often agencies are required to engage in needs assessment for funding and/or accreditation. Even when not compelled to do so extrinsically, many agencies engage in a component of assessing the community, and include it in the annual report, or report back to funders. Find a way to integrate your peers into the needs assessment process.

   Look at your organization’s annual report and identify places wherere peers can help with distributing surveys and collecting data. Leverage the fact that higher ranking administrators often find this work lower priority, and help take it off of their plate. This also gets your peers face to face with community and stakeholders.

   Ongoing education will be key for stakeholders to truly understand and appropriately utilize the peers within the community. Offering of CE’s (if you have that capacity to provide CE’s or, collaborate with a supporter who can) that includes education and training on the utility of peers, recovery oriented systems of care, recovery management, etc. Faces and Voices of Recovery is another great resource for you.
Also, working with the peers on boundary setting for what is within their scope and not within their scope. Concurrently working with their supervision to also understand what is within the peer scope, and to support the peer in boundary setting. Understandably this is easier said than done in a larger behavioral health system context, and it helps to have executive leadership on board, which speaks to your question.

5. Can we have the two places Jenna just listed to find more research on Peer work?
   A: University of Texas School of Social Work Addiction Research Institute, and publications by Robert Ashford and Austin Brown. Also, Recovery Research Institute is a great resource.

6. Could you please provide examples of PRS role and list of required initial training?
   A: This varies from state to state, and should be determined by your local certification entity for peers. In Texas, for instance, we have a state certification training that is a requirement. But that might look different in your state. You can check with IC/RC for your state’s board info, if they are a member of IC/RC. 30 states are members.

7. Do you have a requirement for how long an individual has to be in recovery to apply for peer support role?
   A: Because there were no regulations and/or rules associated with recovery in general when we began development of our Initiative, we initially asked our providers to make sure Peers/Recovery coaches had been in recovery at least two years before sending them to a Recovery Coach Trainings.

8. Could you provide any example documents on recovery plans that can be collaboratively established between an employee and supervisor?
   A: A Recovery Plan is used in providing services between a PRS provider or clinician and client/program participant. A supervisor would not work on a Recovery Plan with another employee or someone they are supervising. This would put the supervisor in a position of being both the therapist and supervisor. Supervisors should avoid dual relationships that have the potential to interfere with the quality and objectivity of their supervision.

9. What are the Block grants? We currently have to pay Peer Support at a wage that is lower than case managers since Medicaid reimbursement is set at such a low rate. Any further recommendations to help with funding peer support roles at a liveable wage?
   A: The Substance abuse block grant is SAMHSA’s system of providing federal dollars to States in order to support the implementation and development of Substance Use Disorder treatment services. As it relates to wages for peers, in Texas it would clearly have been a concern if we had created a structure that would allow providers to pay Peers/recovery coaches more than professional staff/licensed counselors. So, for those programs funded by the State to develop Recovery programs, we requested that they only pay Peer staff between $12-$15 per hour. Could they pay more if they wanted to, yes but not through the use of State funds.

10. Just to clarify...stand alone recovery centers are not funded and integrated ones do get funding?
    A: No, just to clarify we funded both stand-alone recovery community centers and integrated treatment programs to pilot our recovery initiative. The integrated Recovery approach presented an opportunity for us to have clients introduced to recovery support and recovery coaching as soon as they entered the treatment programs, this allowed them to create a relationship with their coaches as soon as they were admitted into treatment, relationship that we had hoped would continue once they returned to their community.

11. I’m in San Antonio. I completed the MHPS instead of Peer Recovery Support Specialist, since the MHPS is Medicaid covered and PRSS is not. Should I consider taking the PRSS in the future? I am in recovery from a mental health diagnosis and substance use disorder.
    A: Here’s what I suggest, having both certifications would make you more marketable in the current environment, however what you need to remember is while the implementation of the Medicaid bill (HB1486) allowed for providers to bill Medicaid for recovery services, the rates aren’t that lucrative.

12. What do you do when you have an employee who is having trouble passing the peer exam?
    A: That one is difficult, but from a supervisory standpoint, it may be time to find out if the employee has some historical difficulties with test-taking. Are there any special accommodations that can be made, and does your certification board offer alternative testing methods. Not everyone is good at test-taking. Also, perhaps setting up some study time and quizzes as part of supervision would be a helpful process. Many people in early recovery need more support for developing their own time management and discipline. Simply ask your employ, “What can I do to
support you?” may make all of the difference in the world for him or her.

If your state is part of the IC/RC board, then they should be able to make accommodations:

Individuals with disabilities and/or religious obligations that require modifications in test administration may request specific procedure changes, in writing, to their IC&RC Member Board PRIOR to scheduling an examination. With the written request, the candidate must provide official documentation of the accommodation requested. Submitted documentation must follow ADA guidelines in that psychological or psychiatric evaluations must have been conducted within the last three years. All medical/physical conditions require documentation of the treating physician’s examination conducted within the previous three months. Candidates should contact their IC&RC Member Board to inquire about other necessary documentation. Contact information for all IC&RC Member Boards can be found at www.internationalcredentialing.org.

13. What is a reasonable salary range for a certified peer advocate? is there money available to help fund salaries?
A: In Texas, we recommended to our Recovery programs in the past, between $12 and $15 dollars per hour, from a salary perspective it averaged out to about $30,000 per year. In Minnesota, we advise starting salary $36,000-$39,000/year ($17-$19/hour).

14. Can we define lived experience? Alaska does not really have peer certification requirements.
A: Generally, lived experience requirements refer to an individual’s lived or personal experience having a substance use disorder, mental illness, or co-occurring disorder, including the shared understanding of loss or changes to social inclusion. relationships, employment, and self-worth.
Alaska is not part of IC&RC, although 30 of the states are. As such, it is considered a benchmark of universal standards nationally. Here is the link to the candidate guide, which should be very helpful for understanding what is general expected, and accepted, nationally.
https://internationalcredentialing.org/resources/Candidate%20Guides/PR_Candidate_Guide.pdf

15. I have my certification for National Peer Recovery Support Specialist and I haven’t been in any type of training on Peer Recovery Support. I was wondering would the NAADAC website be the best website to find training?
A: In order to obtain the NAADAC NCPRSS certification, you must have a minimum of 200 hours of direct practice (volunteer or paid) in a peer recovery support environment (supervisor-attested) and must provide evidence of earning 60 contact and training hours (CEs) of peer recovery-focused education and training including:

- Must include at least 48 hours of peer recovery-focused education/training, including education in documentation, community/family education, case management, crisis management, Recovery-Oriented Systems of Care (ROSC), screening and intake, identification of indicators of substance use and/or co-occurring disorders for referral, service coordination, service planning, cultural awareness and/or humility, and basic pharmacology.
- Must include at least six hours of ethics education and training within the last six years.
- Must include six hours of HIV/other pathogens education and training within the last six years.

Feel free to reach out to Kris Kelly, Kris.kelly@wisc.edu with questions on PRS training in your area.

16. How do you discuss someone’s recovery experience/status without going into a risky HR area?
A: Equal Employment Opportunity Commission (EEOC) guidelines allow employers to refer to psychiatric disability within a job description and posting if having had this particular life experience is considered to be related to an “essential function” of the job. In this context, it is completely appropriate to ask questions such as, “In this role, how do you envision using your lived experience to support people with mental health and substance use conditions?”
In contrast to the pre-offer phase, once a conditional job offer has been made (and before an employee starts work), employers may ask disability-related questions and may also require medical examinations but only if such questions are job-related, consistent for business necessity, and required for all other entering employees in that same job category.

17. I work at a state university where it is against policy to ask someone if they are in recovery. Have you seen this
before? And how do you navigate this when hiring?
A: In general, because of ADA, EEO, and a slew of other civil rights statutes, it is illegal to ask people how long they have been “sober”, etc. What you can do is specify your job postings requirements, e.g. two years in recovery, and ask at the interview if they meet the stated requirements. Legally, that is about all you can do. Many states have considered two years as a general requirement, as it typically infers a candidate is beyond any Post-acute withdrawal, however there are no guarantees, as I am sure you know.

18. What successes have you seen in child welfare programs where peer specialists are utilized, considering the care plans are often not voluntary and a peer concept is voluntary and mutuality?
A: Yes! A great study out of Illinois! It is important because it is longitudinal, over five years. https://news.illinois.edu/view/6367/207025
Recovery is Happening in Rochester, MN has also had great success with its Parent Recovery Liaison program: https://www.recoveryishappening.org/programs/parent-recovery-liaison/

19. In Florida we have found that most trained peers need lots of self-starting research on available resources as they may know the resource for their own recovery path, but there is so much more they do not know. What are some of Great Lakes’ tips on gaining this knowledge?
A: This is a skill set that will grow with experience. It is helpful if employers allow PRS providers office hours to explore local resources. Employers or supervisors may ask the PRS providers to create a portfolio of local recovery resources as a way to focus efforts of expanding the PRS providers knowledge and skill set. Here is a resource that could be used as a starting place: Multiple Pathways of Recovery: A Guide for Individuals and Families: http://www.williamwhitepapers.com/pr/dlm_uploads/Multiple-Pathways-of-Recovery-Guide-2018.pdf

20. Our program had a very short runway before launch of a peer support program in our state. Our agency straddles state lines. In one state, peers were well on their way for years and in our state, PRS only began about four years ago. We are told we are creating the program as we go along. Is this a common problem? Should we stop expanding our program in order to develop the current roles we have going out into the community? Do you have any recommendations for how to address our supervisors and other management staff to let them know that we should have a clear direction before we send in the peer?
A: This is a common problem, as providers are enthusiastic about utilizing Peer Recovery Support Services but underestimate the value of building a strong program foundation. It is worth putting together a proposal that addresses the areas of need and present it to county, state, or organizational leadership. The Peer Support Toolkit is a valuable resource in this process: https://dbhids.org/peer-support-toolkit/

21. Given the current rate of change in our industry, how do we address generational differences between Peers, Staff, and Patients (“old school” versus “new school”) to avoid problems with misinformation or conflicting information within our program?
A: It is essential that organizational leadership is vocal and involved in addressing misinformation and conflicting information. As a PRS provider, working alongside staff that may be resistant to change is an opportunity to use skill sets learned from being a PRS as a way of navigating these difficult conversations; validating, reflecting, summarizing the colleagues experiences. In my experience, I found it helpful to find a PRS Champion from outside of the organization, that is known and respected by the organization leadership and staff. This champion can offer training and education on how to integrate Peer Recovery Support Services (PRSS) and address concerns during the training sessions. They can also address two key components of PRSS; Advocacy is part of the PRS role and integrating PRSS is a transformative process that intentionally disrupts the ‘business as usual’ environment.

22. What are your thoughts around PRS working in clinical institutions?
A: I think it varies across organizations, culture, and staff, and happens all of the time. Whether it is done with efficacy or not depends on how well the culture was prepared, needs assessed, and role clarity specified for the entire time before peer service implementation begun. There are few slides from the webinar that cover this, with some suggestions.

23. What about a CPRS having dual roles; such as peer support (in one area) and CADC I in another area of the same organization?
A: Early in our Recovery Initiative’s development, we encountered this issue, but considering the consequences we
were able to foresee, we made a decision not to allow licensed professionals to become PRSS, because there were duties and responsibilities the PRSS’s would have to perform that Counselors would not be comfortable with performing, and that could result in a setback for the people they were working with in the program.

24. How might a Peer Recovery Services department educate the role and importance of the peer role (recovery based) to a psychiatric hospital of 2800 staff who work off the clinical model?
A: One place to start is having conversations with the leadership of the psychiatric hospital. The leadership team will need to articulate a clear vision for the Peer Recovery Support Services, including the value of PRSS and anticipated barriers. The change must be endorsed and promoted from the top down and implemented from the bottom up. After achieving buy-in or sponsorship from leadership, form a Change Management Team comprised of members that are empowered and equipped to plan and implement change within the organization. The Change Management Team can lead the charge and decide what types of training, education, and resources are necessary to integrate PRS providers into the clinical team. Consider contracting with a recovery community organization or another local agency that employs peers to provide training on Recovery Foundations and Peer Recovery Support Service Basics.

25. How is staff splitting by clients or staff (Peer support vs. licensed professional) addressed within an agency?
A: We encouraged executive leadership at our funded programs to insist on having good internal communication and collaboration among the Peers and professional staff, that commitment helped to reduce staff splitting.

26. Is there a healthcare model using Peer Support other than in the Behavioral Health profession?
A: Peer Recovery Support Services are used in primary care. FQHCs, CCBHCs, Emergency Departments, Jails, Prisons, Treatment/Recovery Courts, and many other non-clinical community-based settings. Community Health Workers are trained public health workers who typically are trusted members of the community where they serve as a bridge between communities, healthcare systems, and state departments.

27. With this virus, and being put on a stay at home demand, what do you see happening with our recovering addicts that can’t reach out and go to groups, meetings, etc? Also, what are the peer advocates doing to help the situation?
A: As it relates to how our coaches and recoverees are handling the stay home demand and continue their work, it’s a little challenging but workable. As a State agency, HHSC are relaxing some of the requirements initially imposed to allow our programs to purchase tablets and cell phones to continue some level of work with their clients. Also some providers are allowing coaches to work from home and take turns coming into their facility.

28. Kris - Can you provide what Peer Support can get involved? For example you mentioned the Peer Support Alliance.
A: Depending where you live, there may be a local network of peer providers that lead the advancement and development of the PRS profession. I would start my search by connecting with a recovery community organization in your state.

29. Jenna - who should we contact to ask what our community needs in Lansing Mi?
A: The people who utilize the services, which is quite an undertaking. This can be done with a community listening forum, however, I would not just try to launch one of those without a messaging campaign of some sort first. Get to know your prevention coalitions and ROSC partners, if you have those available. Also, your local MH/SUD boards/departments, public health, housing providers, housing providers, harm reduction advocates, the VA, and other social service providers. There are some great resources on needs assessment on the SAMHSA website. But don’t reinvent the wheel. See if any of the other community partners have already done a needs assessment. Also, USDA has a great opioid misuse map and Community Commons have put together some great tools as well.

30. Do you think it is important for a Peer Specialist, to include with their lived experiences, to also share what they have worked on in counseling? As well as how long in regards to being hired? I have personally seen certain
behaviors and ways of thinking in some peers, which could be a problem that leads to relapse.
A: Only if that is something they volunteer to share, not because it is asked of them for work. In fact, that could be illegal from an HR perspective. As well as how long in regards to being hired? No, likely that violates ADA and EEO laws. Consult your HR department before asking any personal MH/SUD questions of your staff.
I have personally seen certain behaviors and ways of thinking in some peers, which could be a problem that leads to relapse. This can all be addressed with good supervision and agency support. Asking a peer “how can I support you” can go a long way for addressing your concerns and observations.

31. How can you turn around burnout of PRSS?
A: Our Recovery coaches participate on a monthly wellness call with a national consultant that focuses on self care, these calls are reserved for the coaches and supervisors. The call allows them an opportunity to help themselves and avoid the possibility of burnout.

32. Currently looking to work with a Large Non Profit and looking to create a Value proposition statement for creating a contract? Does anyone have access to a template?
A: Here is a helpful guide from the National Council for Behavioral Health: https://innovation.cms.gov/files/x/tcpi-valuepropguide.pdf
Dr. John Kelly (Recovery Research Institute) and William White both offer data that can be used in creating a value proposition statement.

33. Are Peer Counselors able to do group sessions? Or do they need a licensed counselor with them?
A: They can do non-clinical, peer led groups, but not process groups. Clinical process groups should be separate, and conducted by an appropriately licensed professional.

34. I’m a Certified Peer Recovery Specialist in Virginia. I have been hired by a local Community Services Board to stand up a Peer Recovery Specialist Program. Right now they literally have nothing in place. Are there any resources, tools, or templates available to help with program policies and guidelines?
A: I think you can get technical assistance from The Association of Recovery Community Organizations. CAPRSS is also a great resource, but probably more advanced, for orgs that are already up and running. You can also get TA from Opioid Response Network, if any of the targeted population includes opioid use.

35. What support is available to clients for peer support during COVID-19.
A: As it relates to how our coaches and recoverees are handling the stay home demand and continue their work, it’s a little challenging but workable. As a State agency, HHSC are relaxing some of the requirements initially imposed to allow our programs to purchase tablets and cell phones to continue some level of work with their clients. Also some providers are allowing coaches to work from home and take turns coming into their facility.