>> The broadcast is now starting. All attendee are in listen-only mode.

Hello, everyone, and welcome to today's webinar on building a successful culture in your section 1 of our six-part peer report discovery series, presented by Kris Kelly, Jenny Neasbitt, and Philander Moore. The support series is provided as a collaborative effort between the Great Lakes ATTC and NAADAC. The Great Lakes addition technology transfer center is located of Wisconsin Madison for enhancement and is funded by SAMSA to help people and organization to implement effective practices for SED treatment and recovery services. The Great Lakes ATTC serves the states of Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin, considered health and human services region 5. This is Samson and I'm the director of professional development for NAADAC, the association for addiction professionals. I'll be the organizer for this training the webinar dot www dot NAADAC.org slash webinar. Make sure to bookmark this page if you have not done so already to stay up to date.

You can use that arrow at any time to minimize or maximize the control panel. If you have any questions for the presenters, just type them into the questions box. We'll gather and collect all of your questions and pose them to the presenters during our live Q & A. Any questions we do not get to we will also collect from the presenter and post those questions and answers on our website. Lastly, you'll notice the handouts tab. Right underneath the questions box. You can click here to download the PowerPoint slides from today's presentation and a quick reference guide on how to get your CE certification from this webinar.
All right, now let me introduce you to today's presenter. First, Kris Kelly is the Minnesota State project manager for the Great Lake ATTC. She is also a woman and long-term recovery and subject matter expert on peer-based recovery support services. Kris has worked with state and local government, recovery community organizations, treatment courts, withdrawal management, detox and clinical treatment developing best practices for integrating support and services.

As former executive director and director of programs of a Minnesota-based recovery community organization, Kris is a leader in the peer support movement in Minnesota. She has presented at state and national conferences on topics ranging from supervision and peer-based recovery supports and integrating services in behavioral health organizations to recovery oriented systems.

We are also very fortunate to have Jenna Neasbitt, also a person in long-term recovery, using her expertise and personnel, clinical policy program analysis and administration to enhance recovery oriented systems of care and behavioral health. Jenna holds a master's of science degree in industrial and organizational psychology, works with the Samsa funded opioid response network, is a volunteer site reviewer with the counsel on accreditation for peer recovery support services sand a training adjunct at the national recovery institute with faces and voices of recovery. The coach certification, the recovery coaching, and a recent article published in addictive behaviors, an international journal in 2019 entitled responding to the opioid and overdose crisis with innovative services.

The third presenter of this incredibly experienced team is Philander Moore, a retired Texas health and human services employee 27 years where he served as a unit manager for the substance use disorder section. Philander orchestrated the implementation of the Texas recovery initiative in 2010 as well as the first recovery oriented system of care in the great state of Texas. Philander has a master's of art in human services degree from St. Edwards University in Texas and is a LCDC, licensed dependency counsel.

Everyone at NAADAC delighted to provide this webinar to you in collaboration with the Great Lakes ATTC. So Kris, if you are ready, I will hand this over to you.

>> Thank you, Samson. Welcome, everybody to the -- to today's webinar. I'm really pleased to be presenting with both Philander and Jen, that it's been exciting project for us to build the content together. So today we're going to be talking about the organizational fit of peer recovery support services, some things you can do before you bring peers on or even once they're hired to anticipate and address concerns within your organization.

We're going to talk a little bit about how to employ a organizational walk through and different self assessments you can do to see if your organization is recovery ready and ready to integrate peer recovery support services. Throughout the training today, the webinar today, we'll be identifying different training and resources in ways to orient your current staff when you're to bring on peer recovery support services. So we're going to start off today with a polling question to get an idea of who is on the call, the webinar today. So does your organization currently employee peer recovery support services?

>> Sure. Thank you so much. This will be your first of many opportunities to, let's see here. I think we launched the poll and lost it for just a second it. May be a technical
hiccup here. The question is asking, does your organization currently employ peer recovery support services. Oh, we did not get this one in. So just a little hiccup so just everyone as a heads up, due to a overload of bandwidth GoToWebinar is going to have a few hiccups, one of is polling questions are flicker, we just lost this one. We'll try for the next ones.

Everyone else, please stay tuned for the rest of your opportunities to connect with your webinar. We were not able to capture this poll.

>> Luckily, upon registration, Samson was wise enough to ask some questions beforehand, so it looked like about a third of our participants who had registered were in leadership positions, a third were in clinical staff positions, and about a third were in recovery support positions. And so just to get an idea of who our audience was, I'm going to kind of speak to general guidance for if you're considering integrating peer recovery support services within your organization. And so I think my professional history was I came -- I went through a peer recovery coach training in 2013 and that was really my first experience with peer recovery support services and it was nothing short of life changing and so I started working for Minnesota recovery connection, first as a peer. I developed some different programs and really worked my way up to director of programs, learning to embed peers within drug courts, within treatment facilities, detoxification centers. I've worked with alternative peer group within a recovery high school and really kind of got a general lay of the land about how to integrate peer recovery support services. And really with that professional history what I learned from that experience was oftentimes we thought about how we're going to integrate peers in to our service settings once the peer was hired. And a lot of times what would happen in those circumstances is we would hire on the peer and suddenly the onus of expanding that support or advancing that profession within the organization fell back on to that peer. Generally speaking peers come in sort of a at a entry level position, they're peer professionals and they don't have the leadership role within the organization to do all that work. So it really got me thinking about how can we best prepare organizations and help people start thinking were from the first time you really consider the question. Are we ready to engage peer recovery support services in to our particular service setting? And so that's a large part of the impetus for today's webinar was helping organizations, teams, and individuals, whether you're in leadership or clinical or administrative positions, have some questions that you can ask yourselves to start to think about that.

An important part of peer recovery services that we hire a peer on to our team, we're actually inviting the voice of the people we serve, kind of on two levels. So the individual with lived experience so peer recovery support specialists or recovery coaches, our people with lived experience in both addiction and recovery so they're using those tools and skills in addition to some addition 58 training they've received to provide direct service to participants in your services. So they've bring the lived experience of having navigated experiences themselves. And also part of the role of the peer recovery specialist is to advocate for the people they're serving. So they're directly bringing the client voice often into the clinical team in to team meetings in to recovery planning and really making, helping the client become an active participant within their recovery journey within your treatment organization. There's ample opportunities, our systems haven't quite caught up with reimbursement models if you're
using reimbursement models for peers to be employed and, you know, reimbursed through different avenues that like Medicaid or managed care but peers also have the ability to assistive outrage, so helping them enter treatment soon, so doing away with the rock bottom philosophy and that people have to hit rock bop to get help but that peers can intervene earlier in somebody's addiction pathway and help bringing them into an appropriate level of service that matches their needs.

And also peers can work with people who potentially have left services and might have a setback or a reoccurrence and then bring them into services sooner than when they are actually experiencing negative consequences of their sub straps misuse. So in looking at just some general questions, some things, organizational leadership or staff might want to start looking at and asking our will peer recovery support services alone with the organizational needs, strategies and policies and what I mean by this is where will peer recovery support services fit within, in to your organization?

So taking a look at it is important to take a look at things like doing the language audit. So is the language we use in our marketing and on our posters and flyers and within our programming recovery friendly language. Does it align with a recovery orientation? Do our services -- our services really hierarchical so, you know, is it a top down approach. How much say do our clients have in their recovery planning? Is that something that's valued in our organization? And then what types of policies might create unforeseen barriers for peer's coming in to work for an organization?

It's really important to have buy-in from your organizational leadership and then it is also important to have buy-in from your staff. So it's kind of a top down, bottom up approach. So you're going to really want people to be in a place where they're willing to be a part of a transformative process. You're going to pointe people who understand peer recovery support as much as and how it might impact and feel different or feel uncomfortable and first and that can work through that change as collaborative team members. You're going to want, the organization that simple sort of pros and cons list so what are the advantages to integrating peer recovery support services right now and what would be the disadvantages?

Some organizations find difficult to find sustainable funding for their peer recovery support services. So we don't want to bring a peer on to staff if we -- you know, if we aren't sure that we can keep their position going in the future. And then there's always an option -- not always, but there's often an option to look outside your direct service setting and partner with a recovery community organization or another organization that currently employs peers to contract and use that opportunity to develop and implement all of these integration tools we'll be talking about today and update your policies and procedures and work through those processes so a peer who gets hired and mentored has support of the contract agency outside of the service setting that they can go to. And ideally peers become active participants in doing all of this work that we really talk to the peers we hire about what's working for them and what barriers can we help remove for them.

Some benefits, so I always like to talk about the benefits of peer support just as a starting point because they are really innumerable. So this is 2012, since 2012 there have been many studies done about the benefits of peer support. Some of them are fiscal. So we've seen a better return on investment. We see our service participants or our clients become really involved in the care planning, so they suddenly see something
like a treatment plan that might feel was written by somebody else, engage recovery planning where the client is actually writing their recovery plan and becomes really active in who else is engaged and involved in that process. I think we can't undervalue the increased hope and quality of life and satisfaction with life that peers bring.

I know for myself when I was coming into recovery, it took a long time before recovery was visible. So, again, as people in active addition, we're really invisible, our media does good job of sensationalizing a lot of aspects of addiction, and there's not a good measure of highlighting and sensationalizing, healthy recovery and so peers bring that into why you are staff.

And so it's a daily reminder, really tangible upfront, in your face, daily reminder that recovery works and recovery is possible and people can and do recover and I think that's really underplayed but an important, important aspect of bringing peer recovery support services in your organization. I just want to talk a little bit about some different programmatic considerations that you can make when you're considering bringing on peers.

So, again, ideally these things might occur before you are at the point where you're hiring a peer. Other even as an administrative staff, these are some considerations you can make when you're considering hiring a peer support worker. So when we talk about recruitment, we're going to want to think about where and how we identify our peer support staff and so are we going to post for our jobs. And are there communities that already trained peers that we can connect with and utilize that as a mark main channel for recruitment techniques.

What I found useful is it is advantageous for a provider to find an individual that he they really like and that fits the philosophies and the knows the values and the missions of the organization and then train that person to go through a peer training. So send them through the peer training. Make that investment in that future worker. And that way you know that person is a good fit. It is really a wise investment. And it reduces our turn over in people leaving the job because it wasn't a good fit.

We want to ensure that the role is designed both by people in recovery from the perspective of people in recovery and also from the organizational perspective. So there's a reason why you're considering hiring peers. And it's important to put pen to paper. It is important to look through your organization and really decide beforehand exactly what is the day to day activity this peer going to look like.

We want to ensure that we're not putting them into roles that are the leftovers from other staff roles. We want to ensure that we're not just replacing or replicating current positions. So I think in some places I've seen what we might call a chemical dependency technician report being replaced by what we call a recovery specialist. And again, that's not a good fit for a peer recovery specialist, so often our chemical dependency technicians might do things like collect a UA or they might be the ones in charge of kind of hemming to moderate behaviors of our clients and holding them accountable in a way that might seem punitive or that. And we don't want to put peers in that position because peers work really hard to build a trusting two-way relationship with our clients and so it is important that we define the role and really separate out before that peer is hired what their day to day activities and overall-purpose is within our organization.
We're going to want to check with our state and figure out what are the certification requirements for a peer at the state level, within managed care plans, within our own organization we'll want to have policy, develop policy and procedures about organizational requirements for those peers. We're going to want to check with what are the requirements of supervision for that peer as do we have the capacity as an organization to have proper peer supervision and what are the, you know, what are the state requirements for that supervisor in order to supervise peers.

And, again, addressing continuing education. So many peers that are certified have continuing education requirements just like our clinical staff members and so we want to be sure that we build in time and that potential school contribution that we're making to help ensure that our peer recovery have access to certified education, it makes sense to them. We don't want to be sending peers just distinctly to clinical opportunities because those aren't the skills that we want to be building with them. We want to be reinforcing core expectancies, helping them learn new skills.

Let's talk about supervision a little bit. So we want to be sure, again, that we have a staff member that will be providing some sort of administrative supervision and also supportive supervision. So we want supervision that someone can get on a regular basis. We want it to be really more of a -- we don't want to just take clinical supervision and make that work for peer supervision. We want supervision that's based in problem solving and skill development, feedback, making sure the peers that are supervised have connection with other peers. So a lot of organizations only have the funding to hire one peer at a time, and so we want to ensure that peer has other people to decompress their day with, to problem solve with, to network with. We see high rates of burnout when peers are really kind of siloed and just providing services without connection to other peer provides.

That's where we can engage our community. So I know in Minnesota we have our peer support alliance which is a network of peer providers that get together monthly and they really advocate on behalf of their profession and their workforce. We have peer support echo so, again, twice a month peers can call in and they can present a case and other peers kind of help them walk through that.

There's in some cases they have robust peer networks. Others I've seen peers utilizing things like Facebook and then, of course, in-person settings at their local recovery community centers and recovery community organizations.

Again, before we hire, we want to think about what will performance evaluation look like? So we want to be able to fairly assess our peer roles and we want to be upfront with that. So we want to be sure, just like any other staff, that the peer know what is their performance evaluations include and what to expect and that those performance evaluations really reflect, again, we go back to that importance of writing a really good job description. So those two things should be in alignment and so there should be no surprises and it should happen on a consistent regular basis.

With individual performance evaluations I would do in my work as a director of programs, I would always do a collaborative process where the person would first evaluate themselves and then we'd go over that together. So, again, taking more of the peer approach to that performance evaluation.
When we're talking about compensation for peers, again, looking at the financial structure of your organization, many peers are hourly. A lot of peers aren't making a living wage, meaning they have to hold down two, sometimes three jobs in order to maintain their peer recovery coaching position within an organization. If you can come in, you know, really choose a livable wage and then make are make that work, your organization will be ready to support a peer recovery specialist when you can make that livable wage work. And then always consider the nonfinancial incentives, so training, recognition, certifications.

So we want to sure too we're looking at documents and information management, so considering how will your peers document their encounters. We want to consider is, how will that information be used so that peers don't feel like they're just documenting information and it kind of goes in to cyberspace, that they can actively see the notes that they provide and documentation are actually used within the services provided otherwise that can be really deploying for a peer experience to feel like again, they're just an adjunct to clinical services that they aren't truly being integrated within the client's recovery process. And last thing I'll say here is the referral system. So again, sometimes it is like the wild west when we bring a peer on to staff and at the we haven't decided about a referral system. So who makes the referral of people who need peer recovery support systems, have you thought that through, is it from clinics or do you kind of buddy up a system where you have peers working with maybe two or three clinicians who maybe specifically provide referrals to that peer recovery coach and we want to track that referral process and again because we want to look at what is the caseload for a peer recovery specialist and that's often reflected in the intensity of your services just like it is for your clinical staff. But we want to think through these prior to being a peer on to staff so that the peer finds their work manageable and rewarding and that we can maintain these employees that we make such great investments in.

So there's several ways, I think it is important for providers, so, here, again, in Minnesota we have the Minnesota association of recovery resources for chemical health or an organization called March which is a behavioral health provider organization. And I think it is important that these provide organizations come alongside their recovery communities and advocate for state support in developing the peer recovery specialist workforce.

If we -- if you kind of take a peek nationally, some states have done that. Many have reimbursement peer recovery support services. I've really had an interest myself in community health workers because states have really taken hold of that and there's many community -- different community health worker tool kits that states have produced that that are useful guides for bringing on community health workers. I chose Michigan as an example here because I thought they took a really innovative and unique approach for how the state agency can help develop the peer recovery specialist workforce. And so what they did is they created a peer liaison role of in community mental health services programs and that peer liaison really provided would be the boots on the ground person who was within organizations that could specifically say here's where our organizations needs and technical assistance from the state or other and they could share, those peer liaisons could keep going, what the barriers were, what was building on strengths and the state could then collaboratively work with these community mental health centers and provide that technical assistance and that
training, whether it was organization wide or maybe it was some skills development for
the peer recovery staff or maybe it was things like we don't have enough computers or
workspace or our peer's really need tablets in order for you to do their jobs effectively.
So it becomes a partnership between the workforce, the emerging workforce, the
organizations that are supporting the development of that workforce and then state
agencies.
So we're going to move on to our second polling question and see if this works.
Samson.

>> That is right. Thank you so much, Kris. Yes, everyone. So I will go ahead and try to
launch this second polling question here in just a moment. The question asks how
many trainings have you attended on peer recovery support services?
See here. It's launched. Very good. So you should be able to see it pop up on your
screen. Clearly you all have a lot of experience in doing this. About 40% of you have
already vote just in the first few questions. As a reminder we've got some awesome
questions coming into the Q & A chat box. Thank you so much for sending those in.
Please keep sending in your questions. We will have a live Q & A with all three of our
presenters towards the end of this webinar. Any questions that we don't get to we'll
post on the website in a Q & A document. So you'll have them one way or another.
Also, thank you for baring with any technical difficulties you've experienced throughout
the webinar. As one additional reminder, at the end of the webinar, you'll received a
sorry you missed or thank you for attending e-mail. Just please note that e-mail has no
bearing on your actual attendance and your actual ability to receive a CE. Please do
not reply to that automated e-mail it. Will go to GoToWebinar. If you do have
questions, you can always e-mail CE at NAADAC.org. Cat, cocoa dot NAADAC at org.
So 75% of you have voted in this poll. I'm going to go ahead and close the poll and I
will share the results so we all see it on our screens and I'll turn this back over to our
presenters to speak to those results.

>> Great. Thank you so much, Samson, I really appreciate that. So this is Jenna
Neasbitt. I'm a woman in long-term recovery. And I'm looking at the poll results and
interestingly it seems to be divided out pretty evenly among those of you who have
attend add couple of trainings some who have attended maybe three to four at 17% and
that's really exciting. One of the things that I really wanted to talk to you guys about
today is, of course, peer recovery support services. As a person in recovery myself, I
have personally experienced and observed some of the confusion that can happen for
the populations we serve in the community as they try to navigate the resources that are
available in the current system. We know that behavioral health systems have had
traditionally and historically gaps where people have had some difficulty navigating
between the systems of care providers and sometimes they fall through these gaps
which has been leading up to some pretty tragic statistics as far as mortality goes. We
know that there's substance abuse disorder has long been a public health concern and
now that we have a pandemic happening around opioid use and some of the
cooccurring conditions that happen for people who use opioids, it has grown even more
concerning for those of us who work in the face of behavioral health services.
Samson, I have forwarded but I have not seen it move forward yet so I'm going to
continue with presenting. In hopes that the slides does change. Within the recovery
support services program array we ply peer recovery support specialists to, you may
have heard Kris refer to a couple of different names, and I'm going to go ahead and lay some of them out for you. Sometimes we consider them as peer recovery support specialists, also called peer specialists, recovery coaches, peer recovery coaches, certified recovery coaches, peer supporters, peer mentors, peer counselors, and sometimes they're just called peers. And so the programs that are special support services and the special staff that they employ can fill the gap that are sometimes existing in the behavioral health system and they work to create a safety net. Again, this is another quick note about the used to describe recovery support services and the peer who is staff them. This language varies widely from state to state. Notably, a title in one state for a particular role may may exist in a different state with a completely different meaning.

So as these services are being navigated by the people who need them the most, these people often find that having to coordinate among and between the different agencies and supports that are provided in the pursuit of their own cannot only be discouraging but can be a threat to a individual's recovery or a resolution of problems with alcohol and other drugs.

So the peer specialist functions as a touchstone for people who are trying to navigate the complexity of behavioral health systems of care. They are not only experts in lived experience but also had you to access services and support. In this way, this might be the most important peer support, returning to recovery from problematic substance abuse.

Peers also advocate for those for whom they work, further strengthening the individual's recovery capital. There have been several peer reviewed strategies for those engaging with peer recovery support services as part of their own recovery which we will talk about. For those unfamiliar, recovery capital describes a person's resources, capabilities and strengths that are favorable to maintaining their desired quality of life. These capital, these recovery capital categories are typically referred to as personal, family and social, community, and cultural. For more information on recovery capital, check out faces and voices of recovery.

So let's talk a little bit about this. The institute for addiction research at UT Austin has selected data on recovery support service programs in Texas since 2015. This information that I'm going to talk to you a little bit to you about is from the 2017 final evaluation report. And the numbers are collected at enrollment versus those collected at one year of long-term recovery coaching. So in the programs we saw that 54% of participants owned or rented their own living quarters at a 12-month checkup when compared to only it 32% at enrollment. Overall employment increased from 27% an in enrollment to 60% at the 12-month market.

Average monthly wages of employed participants increased from only $258 per month at enrollment to $881 at the 12-month mark. These were pretty significant numbers. Additionally, we saw a reduction in utilization of outpatient settings and when we talk about this utilization of outpatient settings, this is not to be confused with what we typically consider a modality of care with substance abuse disorder when we refer to outpatient settings there. So we're talking more about outpatient settings in the community such as primary care, etc.

So we saw those visits which were 4,242 at enrollment were reduced down to 835 at one year. And we also saw a big reduction in inpatient settings with 9,362 days at
enrollment, to only 1,122 days at the one-year work. Also, emergency rooms experienced a reduction in visits from 433 with the start of the program to 162 at the one-year mark. Across the spectrum, the estimate for one year of recovery coaching was almost $3.5 million.

For more of this research, check out the institute for addition institute at the school of social work. Also research on community recovery capital, check out the work that’s been done by Robert Ackburg and Austin Brown. We are finding that connectedness can be scientifically proven.

So with all of these great outcomes, of course we see more of these programs developing. It may be tempting to just hire a peer specialist for your agency and say, hey, we're offering peer recovery support services. And while it is a topic for a different upcoming webinar, the implementation of recovery support services is truly about system transformation which is Philander is going to talk a little bit about do a little bit later on.

Hiring and developing peer recovery support and developing those programs is really not meant to just individually benefit an organization, although, when it is done with education and preparation, developing recovery support service programs will benefit the organization as well as the community at large.

So as we consider developing these programs locally, it is important to examine the why. How will recovery support services fit into your agency's vision and mission? What are your program goals? What outcomes do you anticipate the population you serve experiencing as a result? Is there a demand? Are their other agencies in the community that are already doing this? And, if so, what can you learn from them and what can you do to compliment the current array of services that are already in place? Take a look at what your organization is already doing. Are you a community-based organization that has a specific focus? How would you envision utilizing peer supporters. Is there funding available to implement a program? And if not, is there a plan for developing funding?

What types of measures and outcomes would you expect from implementing recovery support services and what would those goals look like?

I did read through many of the questions that you all sent forward when you registered, and, of course, would love to answer them all, and there were hundreds. But one that stood out to me was log it of does it take to launch a RSS program. Well, the answer varies. And it depends on all of the things we're discussing today. So you are in the right place. The universal answer would be this. If you are going to do it effectively, have you to be prepared to take your time. The development of these services requires a lot of footwork and you can get started by assessing your community.

Far too often programs are implemented without first assessing the need or mapping the assets that a community naturally holds. Not just for recovery support services, actually, we see this happen with all kinds of programs and often. And it is typically because funding becomes available and an agencies will compete for the fund something that they can expand their capacity. It's rude to get in there and do the footwork of lipping to the community and mapping the assets that are currently available.

So please know when I talk about the missteps in community needs assessment or asset mapping, it is not necessarily because of the agency's lack of desire to do so, it is
really, typically, because we have such a short runway for implementation of programming when funding does become available.

So the very nature of the peer work is rooted in this community assessment. As Kris said, we are inviting the voice of the people when we hire on peers and develop peer recovery support services. And this very movement was founded in nothing about us without us. Therefore, incorporated fidelity to the best practices for peer support services truly begins with asking your community what it is they need rather than assuming that you know what it is that they need.

You got to ask questions like where are the gaps, what is already in play, what areas or populations of the communities have identified the most need and what kind of help is needed, where resources do you have in your agency, the opioid abuse disorder, pregnant and postpartum parents, youth, tribal and veteran.

What you are providing. Another question that I saw was why are substance use disorder and opioid use disorder in separate categories and I do want to take a minute talking about that because those are my jam. I enjoy talking about those. These are separate for a couple of reasons and the most obvious is that there have been some significant mortality rates associated with opioids, as you all have seen, I'm sure, and the government, through a variety of different Congressional mandates, has been funneling surges of money in to state systems to so that we can successfully respond to opioid related impacts.

As such, there’s sometimes separations in the data reporting tied to the funding. And another reason that they are often separate is because for too long, opioid addiction has been treated clinically like other addictions, so this typically would include some medical withdrawal management, followed by some form of intensive residential treatment. However, we know that that is not the best practice to treat severe opioid use disorder. And, as such, medication to treatment providers and other opioid efficient recovery support service providers have been siloed in the historically traditional behavioral healthcare space.

So for integration purposes and in order to evaluate the efficacy of this much needed integration, sometimes threes two categories are separate, even though we know opioid use disorder is a subset -- a substitute disorder. In short, a very specific skill set and expertise are needed to address opioid use disorder clinically and within the community and, as you engaging in your community assessment, please remember to not overlook this as a need that to be developed and as far as skill set development goes. So as you’re assessing your community or while you’re assessing your community, the next step is to assess your own agency's readiness.

Kris talked a little bit about this. What is your agency's capacity for implementation of these programs? How ready is your staff and how ready and accepting is your culture?

Do people understand what recovery support services are? It is important question to ask because as I read through some of the questions submitted ahead of our presentation today, it is clear to me that there are many of us' tending the webinar today who don't necessarily have a concrete understanding and that's okay. You're in the right place. I'm glad you're here. In some cases without proper reparation, some of your more tendered and experienced staff may be threatened by the new roles that recovery support service providers bring into the space and they may also experience a
feeling of dismay or being threatened by the fear specialist development. It is important
to fortify your internal collaboration processes by defining roles early on and utilizing a
participatory process to do so. Previous experience has shown us that hiring peer
specialists without consideration may result in a difficult transition to implement services
and, in some cases, turn over may happen.
Peer specialists may be used outside of their scope, as Kris talked about, and they may
be relegated to engaging in the catchall task which can contribute to burn out for peer
staff.
Kris also specifically mentioned the use of peer with regard to collecting urine drug
screens and this has been particularly traumatic as we've been seeing peers used in the
process of monitoring patients and clients and participants monitoring with UDS, urine
and drug screens, clearly invalidate the very pumps and foundations upon which peer
supports have been developed. There are no hierarchies in the work we do in peer
services, and the minute you have a peer monitoring somebody and engaging in that
urine drug screen, then you automatically have created a hierarchy. This looks a little
different in recovery because something that's a completely different webinar.

But with regard to the community-based organizations performing services, it is
pretty much not a good idea for the integrity of the work that we're doing. So as you
consider how you're going to use peers, is there an implementation plan, have you
created your orientation training for onboarding, is there a program description, is there
a job description, are there training and certifications that are required by your state?
So are there trained credentialed peers working within your community and if so, have
you talked to them and their agencies to get a sense of what the implementation was
like for them?

Asking neighboring agencies or trusted colleagues about lessons learned with
implementation can inform your organizational assessment.

So let's backtrack really quickly to the piece about the certification. In 2016, only 24
states had ICRC certification for peers. ICRC stands for international certification and
reciprocity consortium. This is the same governing body that helps addiction
professionals to establish licensure from different states from the states that they were
originally licensed.

As of today, there are 30 state with ICRC certification for peers. But it is important to
note that each state curriculum and each state certification process is different and they
address content of multiple pathways, and, more recently, opioid response and harm
reduction, in varying degrees.

It is essential for peer specialists to be autonomous enough in their own recovery
pathway to respect and support different tasks. That being said, we still see, even after
our almost two decades of RSS implementation, we see a polarization between
agencies that have only ever known 12-step communities or the clinical variety of that
as 12-step facilitation therapy which see them polarized with those to support multiple
pathways to recovery, although we have a seen a reduction in some of this dichotemus
construct in the community.

Just a hint for you, multiple pathways does not mean a variety of 12-step groups. And
what it does mean is the inclusion of groups and support for smart recovery or darma
recovery. It supports medication treatment or medication of assisted recovery
anonymous. And it will include harm reduction work, another harm reduction principals and practices.

In many cases, what we now really see is a need for peer specialists to be familiar with and comfortable with harm reduction approaches, because that's really in keeping with the reality of supporting substance use in the community as well as supporting the stages of change.

Sometimes we see peer specialists who are embracing their certification and training but feel restricted in the agencies that they work if the agencies are monolithic in their approach or if they are only oriented towards the 12-step pathway.

So just as a heart transplant team wants to ensure that a new heart is not rejected, your agency can fall short of optimizing any new recovery support programs if they have not adequately conveyed the roles of clarity for peer specialists within the organizational structure and culture.

The recovery report service implementation is truly a developmental process and it is agency specific. So the time it takes and the community champions that may assist with implementation and to shepherd the process looks different in every community and for every organization.

Inadequate training and preparation for a clinical team that is expected to work with a peer workforce can be disastrous for implementation and integration with peer services if we haven't done the best work in preparing that clinical team. And in results, we can see that the peer role and the people who perform in the peer role end up being degraded in the process.

Likewise, it is important to prepare community stakeholders for implementation and peer services. This will bolster the efficacy of your efforts and your program. If you are able to get into your community and start liaising with law enforcement, housing providers, primary medical professionals, you may develop some of your greatest champions to help not only implement your services but they might also be great avenues for discovering funding for some of the services that you're seeking to offer.

And while this next piece speaks a little bit more to supervision which is another upcoming training, it is really important to note that peer specialists, individual workloads should be closely monitored and adjusted accordingly. And I'm not saying this because they're not competent. They're highly, highly competent and very well practiced experienced individuals. I'm saying this because we often see agencies just dump excessive amounts of work on to their peers such as the catch all or de facto use of them at the front lines technician and that's not okay. All that is doing is supplanting other roles that exist in the agency which creates confusion and sometimes resentment for people who are already performing those roles.

So supervisors are essential to regulating this workflow process, and therefore, they are also essential to the recovery outcomes for the participants in those programs.

It is also important to ensure that your recovery support services policy and procedures are in place not only in place but understood by all of the employees before you begin recruiting for peer specialist staff. This is how your agency deals with, appropriate boundaries, confidentiality and ethical considerations. Ethical considerations as well as social media, etiquette, expectations and policy.
A great resource for being able to develop your policy and procedure is the council on accreditation for peer recovery support services. They have a website. You can check it out as far as if you have no clue on whether to begin for developing policies and procedures, they are a great resource.

Of course, you definitely want to ensure that your recovery support services program and your infrastructure are in compliance with your state statutes that are applicable. So while your peer specialist is an expert in his or her lived experience, it is important to not bring them on and expect for them to do the work of designing and launching your program. This should be squared away before you start to recruit, unless you have specifically added these tasks in the job description and are hiring a tenured peer specialist who has this specific experience.

It some of you may recognize this particular still shot. In is Johann Hari in a famous TED Talk, he proposed that the opposite of addiction is connection. And many of us with lived experience who have struggled with substance abuse pragmatically, we find that this statement is very accurate. Imagine a world where people initiating recovery have a connection with an individual who walks them through their journey, helps them navigate these obstacles, helps them develop their goals, and never once judges them for how they do it or for taking it in the process if that, in fact, occurs. They don't judge them if they sell out, they don't just put the plug in and they don't, like, comments that can otherwise be perceived as shaming. Imagine a world where the therapist here is very restricted by a menagerie of ethical rules in their state has, at their disposal, an extended resource of para professional peer specialists to assist the people who are trying to pull their lives together.

Peer specialists are the connection that has been missing for so long. In the addressing acute chronic substance use disorder which has typically been fun if he would through a cyclical mode of care.

With recovery support services we can begin to look at longer term engagement, early identification, and re intervention and rely on them for more assertive outreach than we have historically been able to engage in.

Peers can go where we have not been able to go before, forging a new frontier for meaningful connections. So now we're going to poll you to see where you are in this process, and it is okay if you're just in the beginning stages of this work. We are really excited about being able to walk you through best practices for implementation. So with that, I'll turn it over to Samson.

>> Thank you so much, Jenna. Excellent section there. The third polling question asks, my organization is adequately prepared to implement PRSS. You will see this question launch on your screen in just a moment there. It goes there. And if you can take a look at those four answer options and answer one that best fits your situation.

Also I really appreciate that quote that Jenna shared, the opposite of addiction is connection and, thank you all, in the time sort of a crazy time of physical distancing, you guys are connecting with us here through a learning platform. We really appreciate you for taking the time to connect with Great Lakes and NAADAC during this excellent webinar. Awesome questions you have coming in. Keep them coming. In case if you did not get the instructions earlier, in your GoToWebinar control panel, you can click on questions and type whatever questions you have for our presenters. In just a moment we will close this poll. I'll give you about five more seconds.
Perfect. Okay, everyone. I'm going to go ahead and close this poll and share the results. And I'll turn this back over to our presenters.

>> Thank you so much, Samson. As we can kind of see here, it looks like about 41% of us are ready to go as it relates to the development of peer recovery support services in your organization. I think that's great.

As you can see, 21% were still considering -- I think it was it 1%, I can't remember. Some were still looking at the developing, I think the majority were ready to go. And I think the information that we're provided here today, we'll provide more information with those that are still a question and themselves of where they are in relationship to this.

I want to thank you, Samson, for the introduction. Thank you, Kris and Jenna, the information you provided up to this point regarding the creation of the peer recovery services? The organizations. My name is Philander Moore, I'm the final presenter here today and I'm going to speak to you today specifically about how Texas went about developing the recovery initiative in the state of Texas here back in 2010. Which, it was somewhat of a challenge to do.

The information that you've been provided so far has really been more about the technical aspect of developing one. I'm going to speak to you today specifically about how we went about doing that here and some of the things we encountered in doing so I managed the SUCK services development and implementation unit here in Texas since 2,000, actually I started that in 2009. Prior to that I was still working for the state of Texas and helping in health human services as a program specialist who primarily went out and provided compliance and funded programs, funded substance use disorder programs around the state.

Shortly after being a specialist for ten years I guess prior to becoming a manager in 2009, I was able to see some of the problems that providers who were funded by the state to provide treatment services started to get a better understanding of what they were accounting -- encountering by way of maintaining levels of recovery and helping people maintain some level of recovery once they greeted treatment. Clearly as you can see it made no sense to treat someone for any kind of addition, whether it be mental health or SUD and then you send them back to the community that lack the resources to continue helping them make that recovery.

I could see that during the time I was there. When I became a manager in 2009, I realized clearly that I had an opportunity there to try to do something about that piece and that whole idea would be to kind of look at it from the standpoint of improving long-term outcome, look beyond individuals of services to ensure that the study with which they went and tried to go back to themes were able to support the optimum health, optimum health. So that was kind of our goal when we jumped into this whole thing about recovery, develop a recovery in this in 2010.

Today I'm going to speak to you a little bit about several things we did and how we went about doing those. Okay. So in 2010, Texas said we embarked on an aggressive, innovative approach through the recovery system, a recovery system, develop an innovative approach to recovery systems of care and peer support programs. What that actually means to me and what it meant to me at that time was that for years I provided primarily just provided treatment services and when people completed them they went back out into the communities I stated earlier. There was no ancillary services available such as aftercare services if you want to call it that, any type of ways to develop them to
get into recovery services, housing services, or any type of recovery programs that would allow them to continue working with people who had gone through the things that they had gone through and thank of 1991, the state of Texas actually created something called the criminal justice treatment initiative where we focus U.S. was about developing in a system that would allow people who were coming out of the criminal justice system to go back into the community and go out of the community. What, at that time, we developed what was called therapeutic communities and transitional treatment centers in the community, and some of those same things that were happening up in the early 1990s were happening actually coming bark in to play right now in the 2000s. So we had an idea of what we needed to do. One of the things I think we now right away is that for years there was treatment programs utilizing block grant fund. Very little GR for SUD services, you know, were actually, it was always limited in terms of the money that the state actually injected in to our treatment facility. All of our money primarily in terms of how we did what we did was treatment out of the -- the SAPC block grant, probably most of it you may be familiar with.

And knowing that, you know, and trying to develop support, I realized right away that that was going to be somewhat of a challenge. Clearly, you know, in addition to that, I'll just say this, you know, Samson had not made the commitment or planned to make the commitment to fund recovery, per se, and/or get the approval for the state to utilize any funding out of the block grant to pay for recovery services. So I realized right now there what you're going to have to do. So in order to move the whole long-term recovery and we had to develop the recovery system to support all of that. We had to start, knowing we had no money to do that. So the development of this is where we started. We started with the whole concept of systems of care and developing what we thought was a modified approach because in most of the places, developing, they were less lawless state versus what he had here in Texas. Texas had 268 counties, a lot of the other states that were trying to do it, like Connecticut, Philadelphia, they were doing it in a much smaller environment, of course, from a reasonable standpoint, and it made it a lot easier. So you could really call it a true rock because the entire system was developed in one area.

We had to work this through developing, in 268 counties and try to keep those people involved. In doing that, we actually at this point today, the development of like 2 to 32 modified if you want to call them, the infrastructure organizational structures right now that they're still in place from what we developed back in 2010. That being said, you the know, knowing how we had to go become about doing this the first thing we had to consider is that providers who around the state who was a customer receiving block grant dollars doing treatment service itself, any work related to SUD was a customer getting paid. We developed a recovery team of folks, part low of my staff, utilization of the University of Texas staff from the APPC a couple of consultant that we use from around the country that helped us, started to go around the state and create what we called a created a system of recovery, so to speak, that went out and trained these communities about trying to introduce this concept into their area. We had to state this in the way that there was no funding involved and they were going to have to do this with the understanding that it is something that they felt was the right thing. We able to get 2 to 32 organizations committed to doing that. 28 to 32 counties, so to speak, or regions to do that. At this point we realized that understanding that no fund is
involved, there had to be a lot of trust and transparency involved which is I think I pride myself on the ability to be able to convince people to do things like this and I still had that relationship developed from years earlier, so I was able to get these organizations, cities and states and reasons to consider doing this. We had to go, get these started, we did what we call forums around the state to introduce the idea. We conducted trainings around the state during that time to try to get this done, and educate them more about what we were trying to accomplish because most of our treatment providers were not accustomed to this whole concept of recovery.

In fact, the idea was completely lost not only to them but it was also lost through that leadership within our state organization. So in convincing our state organizations to allow us to do some of this work we had to convince the providers to be a part of it. In addition to that, I indicate that our recovery problems were also something that we had to try to develop. So we, you know, developed a programs in the state, understanding that there were organizational barriers associated with implementation, organizational barriers such as I think Jenna and Kris has already kind of mentioned the idea of bringing in recovery coaches in to a treatment environment where you're accustomed have having professional counselors in there and they see the jobs being jeopardized and they see the jobs being threatened in some way because you have a recovery coach coming in who they consider that as being a threat to them. So talked a little bit more about how we got to that and how we went about doing that in just a second.

Okay. Okay. So peer operated centers that serve as local resources of the community-based recovery support. People don't live in these centers but rather use the resources, it request help individual, their recovery capital at the community level by providing advocacy, training, recovery information and resource mobilization. Now I have standalone and then I have integrated treatment. Let me talk a little bit about stand alone. One of the things that we did here when we started to develop this treatment initiative was build and then come back and start the building recovery community program within the community. So the expectation of these of standalone, employment element, education opportunities within the programs. Recovery support services, recovery coaches, both individuals in groups, housing, transportation, and other service that is are needed.

So in this state we only have a small number of considering them standalone. I think at the time that we made a decision to try to fudged recovery support services I was able to convince the state to utilize some funding that was not being utilized for treatment. Believe it or not the idea was what we called carry forward dollars that didn't get used. We, in the state of Texas, kept calling it those funds were leftover and we were allowed to use them for different projects as long as we were able to us them within the course of next year because there was no way to know whether those funds were going to be able to be used in the coming year. So we wanted to develop the powers, if you want to call it that, of recovery support services.

We did that by putting out an RFP that allowed us to fund 22 organizations. Those 22 organizations consisted of 18 treatment providers and four if you want to call it standalones. When, in fact, only two of them were truly standalones and the other ones were considered what we call outreach assessment or referral agencies. But in any event, they received these funds. It was about 250,000, I think $225,000 each. But
those funds allowed them the ability to be able to provide a level of recovery support services that were not currently being done in the state. So people, while we were, one standalone, one was integrated. The integrated ed you within was basically the eight teams, the standalones were the four primarily. And they were allowed to pay for services like bus passes and getting people transportation, that those people if they left treatment to maintain some level of recovery and they created a relationship with their recovery coaches while they were also, those funds were allowed to hire recovery coaches.  

And I remember hearing Jenna and Kris both speak about salaries and about what, you know, kind of what people are being paid at the time of the recovery coaches being paid, there was a lot of concerns about that from the level of -- from licensed counselors and what they were thinking in terms of what we were paying, what we were allowing recover row coaches to get paid during that time. So we had, in addition to creating curriculum, we had to also maintain some level of oversight on what these people are actually being paid so that we don't lose control of this whole thing as we were trying to develop it. 

That being said, there was a lot of, when I talked about earlier, I mentioned transparent or not. I'm speaking about this in what we actually did here in Texas. The level of transparency creates was not just internally but externally recently funded, all about funders, treatment providers, so having a relationship with executive directors, program directors and the counselors in those programs so that they didn't see, it was something that was going to benefit those people as they left treatment. So we were able to fund those programs and we got them funded and then we went to utilizing the University of Texas who did our first recovery support services evaluation of those 22 organization that is I mentioned. And that, in itself, she mentioned some of the things about the benefit and the results and some of the lessons learned, but mine is a little different in terms of the benefits being, you know, she talked about how the recovery capital, you know, I think one of the bigger benefit of this is that with talked, we mentioned this with the healthcare utilization, I can she mentioned that, but the healthcare cost analysis indicated about 76% of I don't know but that should have been 76% reduction after 12 months of first enrollment. And then after the entire two-year project that we kind of used this as a two-year approach, a two-year pilot, we saw that it was 73 to 74% reduction in the healthcare costs. 

But she mentioned the actual dollars that were associated with that, but that was the actual percentage that was associated with it. So I'm going to lessons learned and shortcomings of what we look back here. So I think if I had to do it all over again, development of funding based and recovery and workforce. Now, we went about developing those curriculums and getting training recovery coaches and getting them certified and this kind of thing, we had a thousand coaches within the first year that were trained but there was no place actually for them to actually do any work. So in some ways we lost some people. If we had to do it all over again I would try to do something that was a little bit different than that. We developed an approach that, I would have done that specific low for people who wanted to create a stand alone recovery community center because one of the things that readings that I had done is that one of the things states needed to have more is stand alone recovery community centers, we don't have a few of those in most of those in Texas we have a few, but it happened be
beneficial to where we are now because it would allow a person to leave treatment and not be in that environment and get back in their community and when I mention the funding of those, 22 of those are integrated community programs in to a treatment program which made it a little bit different to someone who was completing treatment and then moving and then once they left there, where did they go, back to the environment but it still doesn’t have a place that was separate from treatment that they could go to and be a part of and feel like family of people who were in recovery. Go on to develop a system for collaborating between recovery and treatment.

I think in that regard, I think had I done some things a little different in terms of communication was good in terms of how we related to our treatment providers and our recovery organization, recovery pierce, I think it with have come out a lot better. So those are am soft things I think about when I think about the evaluation process that which within the through when we were developing this piece. I will say this, some of the things I'm doing now, even though I've retired for two and a half years, I went back to work now at the statewide coordinator. So I still get a chance now to condition to watch the vision that we developed here around recovery and the initiative to move forward. I get a chance to still provide some input to those people who are now in management and leadership over the recovery community -- recovery initiative here in Texas. So that said, I will turn it back over. I think I've said all I want to say today probably about this piece. But if you're an organization or a state that is considering this, I think it is probably where you need to be at this point.

>> Great. Thanks, Philander, that was awesome. Lots of great information from both Jenna and Philander. We are coming to the end of the webinar. I just wanted to touch on a couple of tools and then we won't have time too to do a live Q & A but please do continue with your questions in between Philander, Jenna and myself, we'll we respond and provide answers, written answers to those questions. So I just wanted to touch on a couple of tools. So I was able to do a project here in Minnesota with Nuway, a local treatment provider, that allowed me to use tools, I started the project actually when I was working for Minnesota Recovery Connection as a director of programs and he then when I left my role this and came to the Great Lakes addiction technology transfer center continued the work and so two great tools you could look at and they're both highlighted on my citations page here in the PowerPoint are the peer support toolkit or sometimes referred to adds the Philadelphia toolkit and then Nyatechs which is a model of process improvement.

And so how I use those two was I came alongside Nuway and they did, they allowed me to do focus groups with their clients and then I did focus things and asked questions with their entire staff. We provided four-hour training sessions that all staff attended on what is peer support and how is it going to look within our organization. I worked with their clinical viewer advisors to determine what's needed in clinical supervision.

And then when I changed jobs I actually became more familiar with Nyatek and the change leader academy which is actually a one day class that can be you can request through the Great lakes ATTC that empowers staff to do process -- sorry, process improvement projects. And so let's just move forward here once. And again both resources will be have citations. But after we did the initial focus groups and with clients and staff and we did some training with the staff which used the change leader
academy with some staff of where exactly do we want to have peer support within the Nuway process so we had several staff do a organizational walk through to really have the client experience action and so we were able to see places where maybe a peer would be a really, really good fit, we careful up with an aim of reducing the number of clients that were discharged against staff recommendation. So we used these plan cycles to measure when we embedded a peer in a certain point in the flowcharting process willed embed a peer and then measure how effective they were in that area. And we were able to provide other staff and leadership at New way with concrete systems and the impact that the peers had in those areas. And what I thought was really exciting is it really empowered peers and other staff to take the lead and really do that kind of ground up work of doing hey, peer support is super effective in this area or that area. And once they decided it is effective in this area, then you can move on and pick a different part from that walk through and flowcharting to determine, well, let's try peer support here and actually measure again and provide data about where it is effective. And then, I'll just pop back for one second to the to what I call, again, the Philadelphia toolkit and this is available on-line but it walks you through preparing organizational culture, it gives you great ideas about how to recruit and different items to consider in you're hiring peer staff, what the service delivery will look like and then supervision and retention. And then to mention too there are six different webinars in this series and so we're going to address these topics in future webinars as well.

So sorry to talk so fast at you all but I wanted to get that information to you. So thank you, Samson and NAADAC for giving us this opportunity. It was a real pleasure. >> Kris, Jenna, and Philander, thank you so much for this wonderful presentation and for your experience. Kris, thanks for that quick adjustment in the end wrapping where up those tools. Those were really pertinent tools. For those of you who missed it or felt like it was rushed, it was all documented in the slides, like Kris mentioned, the references are there, you can go ahead and take a look at the slides, they're on our website. If you're wondering about your CE credits for this webinar or how to access the recording after the live event, every NAADAC webinar has its own webpage that houses everything you need to know about that particular webinar, so immediately following this live event, you will find the on-line CE quiz link on the exact same website you used to register if for this webinar. You will find live Q & A event questions to send in, we will work directly with the presenters to get those answers posted as soon as possible, and you will be able to go back to the website and right under the CE quiz as you see on our screen, we will post those Q&A questions and answers. Everything you need to be of to know about this webinar, it will be permanently hosted at www dot NAADAC.org slash building -- organization slash peer recovery webinar. And here is the schedule for our upcoming webinars, please tune if, if you can, there's really interesting topics with great presenters, as many of you are turning to telehealth at this time, we are pleased to offer a free webinar on March 31st, 2020, it to 4:00 p.m. eastern as you see on our slide here to provide practitioners with information that are needed to use telehealth during the COVID-19 pandemic. If you have not done so already, please check out our COVID-19 resources page. The website is here on my slide. And being sent to you in the chat box now. It also be posted in the Q & A chat or Q & A document. The website for our upcoming webinar is www dot NAADAC.org slash COVID dash
Opioid health webinar. Again, that is our emergency response webinar. We'll have a few more coming up week by week. Really, what is an incredible start to an exciting peer recovery support series, now, that you finished section one, as Kris mentioned, please make sure to register for the rest of the free series. Our next session will be on April 10th of 2020 on hiring on boarding and integration. You can learn more at www.NAADAC.org, peer, recovery support webinars. Six total sessions in this series, incredible presenters, Dr. Carlo, John Kris will return and Jenna will return. We're also going to include Phil Valentine toward 9 end of the series, just, you know, an incredible set of presenters here and we thanks Great Lakes with partnering with us and collaborating with us on bringing speakers together.

If you are a NAADAC member, your CEs for this webinar will be free. If you are not a NAADAC member, there's a small processing fee as we have to enter new people into the system to get the CEs. If you join NAADAC now you'll have access to 145CEs through our free educational webinars and all receive our free quarterly advances in addiction magazine which is free to and is available for CEs as well.

Please note that at the end of the this webinar when we close it out, a survey will pop up on your screen, share any notes for the presenter, give us feedback, and tell us how we can improve. Your feedback is really important to us to improve the overall learning experience.

We've also got a couple of data collection questions in there for supervisors, leaders of the peer recovery movement, people managers, please, please, please take some time to fill out that that survey. If it doesn't pop up, it will also be at the bottom of your thank you for attending e-mail or sorry for missing e-mail, again, if you get an automated e-mail from go to webinar, please do not hit reply. That e-mail has absolutely no bearing on your attendance. We use separate technology to monitor your live or recorded attendance.

Thank you, again, for everyone participating in this webinar and thank you, again, Kris, Jen, that Philander for your real valuable expertise. I encourage you all to take some time to browse our website and learn how NAADAC helps others. You can stay connected with us on LinkedIn, Facebook and Twitter. Be well.