NAADAC

Incorporating Peer Recovery Support Services in Medication Assisted Treatment and Recovery

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HALEY HARTLE: Welcome, everyone. We are so happy to have you here at today's webinar, Incorporating Peer Recovery Support Services in Medication Assisted Treatment and Recovery. Presented by Maury Long, Samson Teklemariam, Sloane Book, and Will Richardson.
We're so happy you could join us today. My name is Haley Hartle and I am Training and Professional Development Coordinator and I will be the facilitator for this training experience. Behind the scenes, Alison White is behind the scenes who will address any issues you may have that are not specifically for our presenters. In other words you have a lot of support here today. The permanent homepage for the webinars is www.naadac.org so update this website so you can stay up-to-date on addiction education. Closed captioning is provided by Caption Access so look for the Q&A or chat box for the link used for captioning.
We are using Zoom webinar for today's live event. You will notice the zoom control panel that looks like the one you are seeing on my side at the bottom of your screen. There are two main items to be aware of. The first is the chatterbox. This allows you to send messages to the host, panelists and attendees and the second is the Q&A box. If you open the Q&A you can ask questions to the host and panelists. They will reply to you via text in the Q&A window or during the live Q&A session at the end. Questions related to the presentation any questions that we do not get to while we were in the webinar we will collect directly from the presenter and post the questions and answers on our website for you to access. And the chat box we will post any handouts so this will include a PDF of the PowerPoint slides for today's webinar. You can make sure to use these instructions and the handouts and for the webinar today.

Each NAADAC webinar has its own webpage that has everything you need to know about that particular webinar. Immediately following the live event you will find the online CE quiz link on the exact same website you used to register for the webinar. That means everything you need to know will be permanently hosted at www.naadac.org/ to webinar. We also have an instructional guide that is underneath the quiz link to guide you through the process. You can also e-mail us at CE@NAADAC.org. One big note: If you do need your certificate to say live on it for CE purposes, please complete the quiz within 24 hours and download the certificate. There will be a blue download button. make sure that you hit that in order to have that certificate say "live" on it. For social workers stay on at the end of the presentation for a brief two-minute video on how to add your license number to your certificates.

Now I get to introduce you to today's presenters. Maury Long is a regional director for Behavioral Health group. He is responsible for the management of the outpatient treatment services rendered under office based opioid treatment programs, intensive outpatient programs, and opioid treatment programs. Long also works as the executive director for the Alabama Department of mental health in Alabama. Prior to joining Behavioral Health Group he worked for 10 years within healthcare operations where he began his patient care and the treatment. Has been dedicated to the treatment field for over seven years and has experience in a variety of settings including adult outpatient and inpatient, adult intensive residential, court based peer recovery stabilization and recovery centers.

Samson Teklemariam is the VP of clinical services for Behavioral Health Group. an accomplished leader with a history of driving organizational results with L&D solutions. Known for implementing initiatives that support organizational priorities and produce measurable outcomes he has been a leader in the field of addiction treatment for over 10 years. He was formerly our Director of training and development here at NAADAC. He was calm every storm -- an intervention curriculum and experienced in treating trauma related disorders using trauma focused cognitive behavioral therapy and seeking safety. He previously worked for Phoenix House foundation as the national director of learning and development.

Sloane Book is a certified peer recovery specialist and a mother to an amazing little boy. She is actively pursuing a degree in human services and mental health to become an addiction counselor and is in long-term recovery. When presented with the choice to remain in Florida and either end up dead or in prison or take a chance and move to Colorado to redeem her life, she took a leap and moved to Colorado. While navigating through sobriety, she learned she is no longer ashamed of her past and instead wanted to embrace it and try to help others find a way out. Once Sloane felt confident in her recovery she became a certified peer recovery specialist and started to work at behavioral health group in Denver. She realized that using her story and sarcastic personality would serve her life purpose. Every day she connects with new people and helps them on their own recovery paths through support, connection and encouragement.

Finally, Will Richardson is a certified peer recovery specialist with Behavioral Health Group, a Navy submarine veteran and a father of two. Richardson uses his 15 years of addiction and nine years of sobriety along with the techniques learned and peer recovery specialist classes to instill a sense of hope and those struggling with recovery. Richardson realized early on that he can be an instrument of service and piece to those struggling with addiction and help them manage their demons. He teaches people in recovery to embrace who they are. Why? For one simple reason: When you learn about yourself you can turn your biggest weakness into your greatest strength. When you do that, no one can hold your weakness against you ever again.

I will now pass it over to Samson and we will get started with today's webinar.

SAMSON TEKLEMARIAM: Thank you so much, Haley. Sorry it took me a half second to hit that button. Let me hide my panel. Thank you Haley, NAADAC. I'm appreciative for this incredible opportunity to share some of our experiences of incorporating peers into medication assisted treatment settings. I want to shout out to Cynthia Moreno-Tuohy to any and that is the peer movements lifelong champion. She has been a consistent advocate in and mentor and trainer and policy maker and all the above to help us all professionalize and stabilize the peer recovery support profession. From my folks here, Will, Sloane, Maury, I thought it would be great for each of us to share why this topic is important for us before we get into learning objectives. Whoever wants to

go first. I will go last so I can cover the learning objectives. I would love to hear from each of us as to why this is such an important topic for us.
MAURY LONG: You heard the introduction so why peers are so important to me is patient care. They live it, know it and breathe it and they are for me the gateway to treatment for our centers and all that we do. Having someone who is such a vital part of treatment within our region and how much they impact patients positively is a no-brainer. To have them in our corporations working every day and being part of our teams, they are a vital asset to us.
WILL RICHARDSON: That is exactly right. To add on a little bit of what that is, we know how to do it. Everybody wants to get out of the addiction process, but some people do not know how. Many of us like myself are the living example of how to get out of that. That is a huge asset when it comes to recovery.
SAMSON TEKLEMARIAM: Sloane might be trying to reconnect. If you do come back on we would love to hear your why on this topic. Oh there she is. I will let you go before me and then I will share mine.
SLOANE BOOK: As far as the why, kind of like they said it basically takes a village to get through recovery. My biggest why for peer support is when I was going to my own recovery I did not have anybody, I did not know peer support was an option. If I had, it might have taken less time for me to get to where I am today. I think it is really important and a vital step for everybody that is going through the recovery process in order to get out and have the support network they need.
SAMSON TEKLEMARIAM: Thank you all so much. Everyone else in the audience, I would love to hear your why in the chat box although my chat box disappeared. I would love to know why you are here in this training just for 1.5 CEs or is there something about the topic that captivates you. I have some personal reasons but I will share the most important reason for me right now is our workforce is in a crisis. We are almost kind of silly and did not jump to a very practical solution of getting help but we need help. We are always operating off offering help because we are care providers. We have folks with lived experience who have pursued additional education and training and they were doing it in the hopes of being in this field and being integrated in our care system and also helping up with these overload. I am watching counselors spend 30

out of 40 hours and their week not seeing patients but doing follow-up calls and care coordination and not seeing patients and trying to help a client who gets to a grief and loss group group. Then it hits me that that is not counseling. That is peer support and mentorship. There are a lot of things there that I'm going to unravel with three simple objectives: The why, what how. I found the chat box so I am hearing I would love to know what is your why. Those on the team who are joining the training, Sloane, Maury, will. We have some awesome whys in here and I got to see that infamous Kyle Brewer on the best trainers on peer support services and I have a reason to be nervous. Like playing basketball in front of Jordan basically. Kyle Brewer is integral in all the progress we are making in the peer movement. We're going to break it down into why what and how. Going to turn this back to NAADAC to see who is in the room.

HALEY HARTLE: I'm going to launch the first poll now. I give you 10 or 15 seconds to answer. It looks like we have the majority of people who are answering. Last chance to put those answers in there and I will pull up the results now.

SAMSON TEKLEMARIAM: I see it. This is a good mix. At 20 percent are licensed counselors and social workers. Some of you might be if the peers are new to your program you may have been given the responsibility to supervise peers. At 25 percent of the room about 71 people are peers at about 3 percent nurses, prescribers or physicians. 19 percent certified addiction counselors. This is great. Thanks, Haley.

I see all your whys in there. Someone from Scotland and I will not try to say your name. Let's talk about the first objective. I want to get really granular. Intentionally specific. Opioid use disorder patients have MAT, MAT/R, medically assisted treatment and recovery and we have to talk about the setting and be specific when we are talking about the addiction disease and even more specific opioid use disorder. For those of you viewing this presentation I think we can all agree that in its very nature addiction tends to be an isolating disease. Those who are seeking help probably had to push through some really emotional mental and physical barriers that were stopping them from seeking the help they needed. The moment they enter our doors is this rare moment of vulnerability. That opened up or if some people say they hit rock bottom where they found the right support to help them get in those doors. Take a minute and pause and put yourself in their shoes. You may have been in their shoes. What do

they feel? What do they see and experience in that rare moment of vulnerability, when they are coming to the doors of treatment?

In research for those in your care, what we're seeing now is that roughly 62 percent of patients that rate way between zero and one day arrive at their actual appointment in a MAT setting. That's for intake screening assessment for them showing up to their first appointment. Compared to 42 percent who had to wait two or more days for their appointment. Just 20 more hours added -weighted added to the wait time and we dropped 20 percent of the folks who show up to the first appointment. There is a reason for this and I will get to that later. Just remember the wait time is moderately impactful. As they wait. Consider the referral source. How did they get to our door? How stigmatizing was that experience? How many taboo or demeaning experiences have they had as they enter into treatment? Just as addiction and isolation can harm, connection can heal? Peers deliver an experience of connection. We cannot deny that although a treatment provider or care provider can discuss the stigma of addiction, we can discuss the stigma of MAT and share innovative strategies and techniques and pamphlets and workbooks education. The biggest difference is that a peer has actually lived it. I'm going to say something crazy here. It is possible that peers are more experienced in navigating the system of care than we are as licensed professional helpers. We're talking about navigating a very complex and ever evolving system of care that is not getting simpler for folks. It is actually when we are trying to fix access to care issues, sometimes we create more barriers. Peers have actually lived it.

Another unique need that OUD patients have is that patient engagement really does equal patient safety even more so in those 30 to 90 days of medication assisted treatment and recovery approach. The more people who are engaged in treatment, the less they are engaged in negative patterns. These negative patterns that may have led to substance use relapse in the past could potentially leave that to that again. When patients are combining there regularly scare at scheduled therapy appointments with something like methadone or buprenorphine, each screening recession in those first 30 days is vital to their overall safety especially when there are reactions and needs for those adjustment or reactions and signs that are indicating more intensive treatment services like IOP are residential care. There is so much stigma lingering not just for the

general public, but that stigma is still lingering in our professional recovery settings. We have judges as social workers counselors, nurses and even physicians, sometimes carrying their own bias for or against MAT without knowing the data on its efficacy. Operationally, and health care, we are often trying to maintain patient engagement through traditional means like education, education groups, intra- groups, or medication induction groups. Sometimes we have pamphlets we hand out. We think we are doing everything possible to maintain patient engagement when we try to ramp up with these phone calls when people are not showing up to their appointments. If you have been in this field for 12 minutes, you have had to deal with no-shows. We have to think about the power of lived existence. We have to pause and look around our center and see if in our environment or treatment program, do we have someone who is genuinely leveraging the power of lived experience. When we talk about lived experience and peers I would like to give you a disclaimer. We are specifically talking about those peers who are certified who have an accountability to a board or certification board and they have a Canon of ethics just like we do in our field and they are professionalizing themselves and they are providing care and doing it in a safe way in being trained on how to maintain their scope of practice so we can just assume as a disclaimer those of the peers we're talking about. Let me cue Sloane, one of our peers at BHG. Can you share a little bit about your experience?

SLOANE BOOK: Hey. Can you hear me? So I wrote it down so I did not sound like an idiot like I did the first time when I started talking. My story is pretty typical of any addict. I got a surgery, was over prescribed meds. When they cut me off from the medication I was already in a hole. I went down a destructive and stupid path. In the end I lost everything from belongings to friends and family. I made a lot of excuses every morning about why I could not get clean. It was just a vicious and selfish cycle that I participated in for years. One morning I was surrounded by people I did not know in a hotel room that I was not familiar with where I was at. I was overwhelmed with a lot of shame and guilt and I was lonely. I randomly decided to phone a friend and Colorado on a whim. I told him what was going on in my life. He basically said he will buy me a one-way ticket to Colorado. I can figure out how to get to the airport or stay in Florida and either end up dead or back incarcerated. The flight was a week from the day that I called him.

The entirety of that week is kind of a blur, but at some point I got to the airport and I woke up and I was in Colorado. I spent several days detoxing in a basement by myself. It was horrible. Because I was alone, I wanted to give up and go back to Florida, but I stayed and detoxed. I came out of the basement and there is a whole new life of possibilities, but I didn't know what those possibilities were because I had no one to help me navigate through what was going on or what I was able to do. Three months after I moved to Colorado, I ended up falling in love, had a baby so now I had an even greater purpose to stay sober, but still alone in how to stay sober. I tried to go to meetings in different groups but they were always people selling drugs at these groups. A lot of the males in these groups were using them as a dating service and it was kind of a nightmare. Eventually things did not work out with my son's father so I had to figure out how to get my life together was trying to stay sober and rebuild from the bottom. I did not turn back to drugs. I took care of myself and figured my life out. I would just like to point out because I do a lot of recovery capital and always like to point this out. When I came to Colorado, I came with a suitcase that was only half filled with a ratty assortment of close half of which probably were not mine. Now I live in a lovely two bedroom apartment and it's decorated and has an enormous closet full of shoes and clothes and my son has a room full of toys and clothes and I have a car and driver's license. I've never been late with my bills or rent. That is something I have never been able to say before. I'm also a full-time's student and I'm trying to pursue my bachelor's degree and human services. I have an incredible job as a peer support at BH G. It took me a long time to realize that this was the path I wanted to take. I just had my seven year sobriety date on the 18th of January. As far as the effectiveness of peer support, from my own perspective and opinion, I wish I had that when I was getting sober. I wish I knew that it had existed. I did not know it existed until this year and that was because I was applying for positions on indeed and randomly came across BHG I can see in my clients alone like Samson said, we have recently started doing an orientation group the clinic I work at and that is mandatory so as soon as you start your intake you have to sign up for an orientation group. So far we've had one but the one person I did meet I talked to her almost daily now just trying to help her manage her dose and see where she is at. She is staying sober. You can just see a huge difference in people that are

trying to do it alone and other people in the support network there. Sorry. Basically what I'm trying to say is struggling alone is terrifying especially as an addict because you constantly feel judged by everyone. I have learned from a lot of the clients I work with right now that even though there is no judgment from their counselors, they are still scared that they are going to judge them so they do relay things to me that they have not talked to their counselor about, and I am hope I am able to help build a bridge for them to talk to their counselors to work through whatever trauma they are trying to work through and things like that. I think it is probably one of the most beneficial things in recovery. At least that I have found. You need all the aspects, but I think peer support is a huge aspect. It is really effective in maintaining sobriety for a lot of people.

SAMSON TEKLEMARIAM: Sloane, thank you so much for sharing. I hope you find the chat box so you can see some of the encouraging words. You guys were messing me up. I was over here about to tear up seeing the love pouring out. There is something really powerful they were talking about. I love that you said that you wish you had that and now you are becoming that gap. You are becoming that missing block that a lot of folks did not get or maybe are not getting. For those who are still unsure about the power of lived experience, we're going to go into some data. My geek nerds here with me that sit in front of a cup of coffee and read these research studies at night like I secretly do, we're going to get into the data. Are you under the impression that people are not moved by authenticity? If there is a disease that cuts through both should quicker than addiction, please find me. Every single patient that I've ever worked with, authenticity is worth it. There's always a feeling of dishonesty manipulation or they feel like they are here because they are being used by the system, if they do not have connection, a lot of times that healing is blocked. A lot of times we are really pushing through a lot of challenges and turmoil that does not have to be pushed through if a peer were there.

Going to keep going. I have a couple more stories I'm going to share, but let's look at some of the data that we are talking about.

Hopefully, this will be interesting, we talked about how patient engagement leads to patient safety. Now that they are engaged, what do we do with the engagement? Hopefully we retain them because patient retention leads to overall success in

treatment. If you've looked at a lot of the evidence-based models, this is the peanut gallery amen moment. Yes, we know that Samson. Think of a new employee joining your team or workforce. Think of helping that employee orient into your workforce and how that is the top priority because you do not want to lose this person. Now think about the second priority is what we keep them around. One of the most successful models and achieving both goals is through repairing a new employee with a mentor, someone who actually experiences the day-to-day workload and norms. As the leader or supervisor, you could teach them and train them up and give them all the tools and guys in the chair points they can dig around and find out how to do their job, but at the end of the day without connection, their days as a new employee or usually limited. Through pairing a new employee with a mentor, an HR study found that 7677 percent of companies increased employee retention by prioritizing mentoring programs. I'm going to drop this article in the chat box. If you cannot see it or view it, I will email it to NAADAC so they can put her on the website as one of a couple additional resources. Why? Why am I talking about employee onboarding? First because I am a workforce development junkie. I am legit all deep into workforce development. I am passionate about how to better equip people to achieve their career goals in life. Second because that experience of being an outsider coming into a company or feeling like an imposter is very similar to what our patients feel. We talk so much about peers as in who they are, but we do not focus much on what they do. Honestly for centuries, mentorship has been the predominant method of human learning and behavioral change. Has gone through various name changes like apprenticeship or discipleship but a mentor is not just about lecturing and teaching. It is about connection. Have I set it enough? It is about connection.

Let's cover a few critical data points. Let's get through this quickly so I get another story. Again, if you want some of these research studies you will see the citation and research on the research slide slide in the data points listed on the research on the citations resource on the website webpage. Peer support is effective for engaging individuals in treatment and encouraging them to transition from treatment to early recovery. When peers walk with somebody through each step of treatment what we have seen in recent data and it was that recently validated in 82020 also was done in

2016 and 2018 so it is not new news. This more recent study found that 86 percent of patients show up for the first MAT program appointment and these are participants who are involved in MAT setting with a pier. After their first dose, 30 days later, 72 percent are still in treatment. This is compared to a very similar study showing that without peers only 45 percent showed up at 30 days and the number drops significantly. That is 827 percent overall increase in retention just by adding peers.

Some peers might be unfamiliar or hesitant to address the use of medications and recovery groups or in one-on-one meetings but there is new curricula being developed in a destigmatize is the use of MAT and peer led settings. Also coaches and leads peers to know how to say you need to talk to your nurse about that. Have you spoken to your prescriber or Dr. Have he told them about that side effect? Heavy shared with her counselor how you have how you're feeling with some of those emotional changes? There's a lot of information and training and resources. One innovative program in Pennsylvania leverages peers in three rural emergency departments to initiate buprenorphine. A study of this program found that peers increased treatment adherence with 70 percent of patients attending their first follow-up appointment and 59 percent were still in treatment at the 30 day check-in. Peer specialists have been found to support engagement in MAT program in telephonic and seeing why they did make it to their appointment and help them get to the next one picked participants and one programmer not only more likely to enroll in the MAT program, but also significantly less likely to experience an opioid overdose overdose within a 12 month period. Now we are talking about preventing mortality. If you go to our references, you will see additional research that is recent validating the use of peers and how they drastically impact both patient engagement and retention. These are two obvious key factors to overall treatment success. Basically folks cannot succeed in treatment if they are not showing up. It is hard to succeed in treatment if they are not engaged and have not bought in. Please, geek out with me and read these research studies. Each of them are on free public domain. If you stay on till the end of the webinar I will drop my email address in the chat box and you can say Samson I am having trouble finding this article and I have them saved as a PDF and I will send them to you. Later will share more resources about how we can deepen our understanding of why peers are so critical. Write now I

want to know more about you about the audience so we have two more polls. I'm going to kick it to Haley at NAADAC and see if they can help us lunch these poles.
HALEY HARTLE: I will launch poll question number 2 now and you can put your answers in there it will give you about 15 seconds to respond.
SAMSON TEKLEMARIAM: I don't want you to see me take a sip of tea.
HALEY HARTLE: We're going to share results.
SAMSON TEKLEMARIAM: The question was asking that I am appear I were to make setting with a peer, 52 percent said, yes, a little over half of folks here are peers themselves or work in a setting with a pier 35 percent said no and 13 percent said sort of. It for my sort of folks if you could share and elaborate. I would love to know in the chat box so we can close this poll. Thanks Haley. I think we have a second poll, a third poll but second in the middle and I'm going to turn this over to Maury. I will let you speak to the results of this poll as it looks like it is being launched now. Thanks Haley. I know what OBOT and OTP are. And we are definitely not talking about OTP and perimeter Atlanta, Georgia, but I know it OTPs and OBOTs are and I'm going to disconnect and let Maury take over from here.
HALEY HARTLE: We have about 60 percent. So take another five or so seconds and put your responses in there and we will go ahead and end the poll now. Maury you can take over.
MAURY LONG: Good afternoon. Wow so 31 percent said they know what an OTP and OBOT program consist of and 59 percent say no and those are good numbers. As Samson mentioned, what is an OTP. It is not the song by naughty by nature OPP. Close, but no cigar. OTP is an opioid treatment program. It is an FDA approved program or practitioner engaged in opioid treatment of individuals for three approved medications. Those are methadone, buprenorphine, and sometimes –.
These usually make up medical directors, nurses, physicians, medical assistants as well as counselors and, of course, our famous peer groups. Those generally make up our OTP programs.
BHG is the largest network of joint commission accredited OTPs. We could not do it without the mental health counselors, nurses, social workers, care coordinators and physicians as well as nurse practitioners. Without this group it would be impossible so

what we do with that as we come to a holistic group of care. When I'm interviewing people for our programs I tell them that we need people who care. everything else you can be trained, but I am telling people that you can understand that these are patients. I never use the word client. When I first came into the center, client was never a word. Patient was never a word patient. I never expect any patient to be kind and courteous and friendly and caring and understanding or nice to you because when they come into your presence they are in their worst state always. It is our job as clinicians and healthcare workers to be nice and kind to them. When they come to us, we are the only outlet of help and hope and listening ear, and empathetic voice, they come to us with all their problems and needs et cetera. We are that safe place in the safe haven so we are working together to make up an OTP. as well as an OBOT program. Without those core principles and vision, it is a moot point. The goal always is to give them their lives back. If they have not returned to a life of normalcy, in my opinion, we failed. It takes all of everyone listening to make a successful program. Next slide, please.

And not OBOT is an office-based treatment program. The main difference in OBOT and OTP are the regulatory compliance that government. With an OTP you have the three medications the Suboxone methadone and buprenorphine. With the OTPs are regular invited by the DEA and state agencies so the Alabama Department of mental health so it is heavily regulated in comparison to the OBOT were generally speaking the DEA are the only governing body there for the program is there. They generally OBOT solely by physicians a lot of outside doctors they work from there in a OBOT program.

With an OBOT program because it is the most popular, in a perfect world generally patients would generally start from an OPT program and as they progressed they would then go to an OBOT program. For some patients that is not the case but generally speaking depending on their level of dependency on the opioid or drug was, they can progress from one to the other. Sometimes patients start up with a OTP and end up with an OBOT or they come for OBOT and realize thatOTP would be the better structure because it is so highly regulated it is a different levels from the counseling and intensive outpatient so there is more, I will say it's a one shop fits all, but you have more variety at a OTP versus a OBOT.

SAMSON TEKLEMARIAM: Maury explains it so effortlessly. I've been in the setting for almost a year and I call him my Maury Long app and I just love that break down and especially just kind of understanding the ideal versus what kind of happens. There are five key value adds. It is important of the settings to know the context. Maury and I are going to go over some key value adds very specific of what peers do or how they add to our work. The first is patient overload. Has anyone felt this way recently? When I say recently I say the 26 months. I will let you tie the knot on that one. There are more patients to providers to provide all the services needed. It is no mystery we have watched year after year dramatic numbers of high turnover out of the field and none of counselors coming into this field. It is also no surprise that the communities are needed more than ever before. Overdose claims the lives of 841,000 Americans between 1999 and 2019. More than 70 percent of these deaths were due to opioids. This crisis has been exacerbated by COVID-19 in this public health emergency that we are still transitioning through, and we are seeing higher numbers of overdose deaths. We are only able to more effectively intervene in saving lives when we have professional helpers available. I am super grateful because NAADAC has led the mission to professionalize the peers' recovery support workforce but now more than ever, we have to leverage this critical part of the workforce. Every now and then we receive push back on peers, sometimes counselors ask questions like if you're hiring peers, are you hiring less counselors? What counselors? Please find me some. We have over 200 open positions right now for counselors. Please, send them over. This is not an either/or. This is a "yes, and." People are standing in line for care and literally dying because they do not receive it when they need it most. Appears are nowhere near replacing counselors. They are supporting the framework of clinical work and not just for counselors before nurses, doctors, the front desk, patient registration, for every framework of this is a key ingredient for integrated care in behavioral health to really, really work. I hope we can address this more later but let me pass the ball to Maury to talk a little bit about the second key value add.

MAURY LONG: Thanks, Samson. Care coordination is the second point here. We connect their multiple referral sources. Are pure support teams if they are used properly in any OTP or even OBOT program, the bridge the gap tremendously they go out into

the multiple referral sources they know exactly what each peer, who walks to the doors, the challenges that they face. They know exactly the stories and all the things that they have to deal with to get to that place. Would to make sure that they have all the things they need so they can get sustained success within the program. We know that if they stay with the program at least 90 days, they are more likely to see the changes and they are more likely to feel the change to become stable patients. We cannot help them unless they are there. We have to take care of the initial needs that they have in the care coordination. We reach out to the community and what referral sources do you need. Do you have jobs, connections, things in the community outside, do you need clothes, food, shelter? We collaborate with MOUs and other programs within the community to bridge that gap that they need whether it is family therapy care coordination vocational support the peer is vital. They bring ideas to us and we listen to the things that the peer support teams bring to us in regards to what the patients need on a day-to-day basis. That can make a difference in a positive change in their lives. The next one we have our missed appointments and follow-ups. How does a pure help with missed appointments and follow-ups? In our programs a part of her introduction phase to the OTPs or OBOT programs, our peers are part of that program process. They connect with every single new patient. They contact them every day for the first 90 days. There's not a day that goes by that they don't walk in the building that that peer does not have a conversation checking in how are you feeling today, how was the medication and how are you adjusting to the medication?'S or anybody want to talk to? How is your counselor? With that, at any point at any time, if that patient misses a day, those peers are critical. They call and follow up. If they miss more than 48 hours, the peers reach out on the phone and call them and see where they are. They sometimes even take it a step farther and drive out to see where the patient is. Why are you not coming? What challenges? They help bridge those connections. Knowing that somebody cares about them is always key. Just hearing that voice, of the Sunni testimony if it is a peer connecting and saying we miss you is everything okay. It brings them back into the fold where they can get the help that they need. In the centers. Or part of the next slide talking about GPRA. Within Alabama, we have grants that required a source. It is a government program results assessment. Our peers before

being placed on the grant, our peers sit down with patients to go over the information, go over the grant assessment, and go over the information needed to make an assessment if this patient fits within the grant criteria. There's a small set of criteria that the patients must fill out that is important to the category. The peers assist with that process. A lot of times peers bring so much of an asset and counselors may be tied up in sessions and follow-ups and adjustments, the peers bridge the gap and fill in the roles doing these assessments, the initial assessment and then a follow-up session that happens every six months. Another assessment to make sure everything is still on track and still recovering properly. Financially they are on track and making the steps that the patient initiated they want to do in regards to that.

Finally, point 5 peer recovery led groups. We allow for that process in our first 90 days as the peers are touching bases daily and interacting and engaging daily. They join the community we offer them and allow them to lead our groups of care whether it is telehealth, face to face, small group sessions, and we allow them to bring their ideas to the groups. Samson you can interject as well in this discussion.

SAMSON TEKLEMARIAM: The prom that we have had as we have not talked about how to make peers a sustainable part of our treatment system, a part of our care that was integrated and woven in. This last value add is what accomplishes that as having peer lead groups. I'm not talking about twelve-step groups. Maury talked about a few of them but smart recovery has a model. Peers of a billable service as a pier should not be doing the whole IOP since it is an outpatient program but they can certainly be covering one-third and that is validated in Medicare as a valid code. It is a peer support service that is added to the IOP. We use it as about one-third of our IOP. It is an example of integrating peers. I see some love and shut out for smart. Has some incredible interventions and curriculum and workbooks that peers can use in groups to navigate folks through care. The little cheat code, if you have a weight line or a great wait group or you have not you don't have enough providers on hand, get them into a peer group. A peer group works great as an introduction to the program to the environment. That way they are just not waiting in dangerous situations and connecting with people. There are a lot of programs who are using peers as a way to group. I'm good actually going to turn this over now. I'm over here talking about this theoretically.

I'm talking about incorporating peers. Let's incorporate another peer into this conversation. So, Will, let me hand this over to you. This is Will Richardson, one of BHG's peer counselors in Virginia. You can talk about your story and your experience.
WILL RICHARDSON: Awesome, Samson. Thank you very much. My name is Will Richardson and I am a peer. The thing that a peer can bring to this situation is the lived experience in the lived experience of something that you cannot deny. With that my story is a lot like everybody else's. I had an addiction problem and that led me to making certain decisions and then those distant decisions turned into consequences so when you have the consequences that come out, the more addiction, the more the substance use is what actually makes it even worse. It worsens the situation until you are wrapped up into a storm. You're sitting there in this storm and looking around and trying to make decisions on how to get out of the storm, but you do not know how. You're making decisions based on your experiences and your experiences in addiction and your storm gets bigger and bigger. Then you move and bring the storm with you. When the storm goes with you, it encompasses wherever you are there. You become the storm because of these consequences that build up in these bad decisions that build up. I had lost a marriage in connection with my two children and had lost jobs. I was lost until somebody said why do you go to this place over here. It ended up being a peer run program. I have no idea that even existed. I thought it was just AA or NA or Smart. And I thought it did not work for me in this and that. I then went to the peer program that is run by peers and I showed up angry and depressed and skeptical to be honest because I did not trust anybody. I did not trust myself and if I can't trust myself I can't trust anybody else. To escape all that, there is somebody that just said you know what? Follow me. I was like okay. I followed this man and he walked me step-by-step through this program and I fought him every single step of the way until something broke. It just came to me and then I said you know what, I get it. Because of me listening to somebody else and that person ended up being a pier. It did not take away all my consequences because you stuff to turn around and deal with that but when they became the storm that I did not want to be made me do things I did not want to do then I became a completely different person than I was actually that I actually was. There is nothing that I like about how to go back to that person that it was before the storm

because you forget who you were before the storm took you over. That I step out and look around and think now what. Then somebody else steps in and says this is my friend Bob and Bob says we can do ABC and I talked to this other person and then you start building that peer network around you, you start getting other people's solutions. The solution is on leaving the storm behind you, taking that experience that you got there and moving it forward. It puts you in a foreword moving position. It makes you hungry about what you want to do. It took 15 years for me to lose everything in my addiction and I had to learn that it was not going to happen overnight. There is a process to this. You have to accept the things you want to do. But Bob over here is telling me that acceptance is the key. Fine I accepted now what. Then you have to put in the work. Every day. That is the perseverance that you go around and you go through that and you have to persevere through that. This is all easier said than done. When somebody walks through the front door to get some help, the counselor is telling them all the right things to do and they are not believing it. Then here comes a peer person who says no, they know exactly what they are talking about but here is how I did it. Here is how I navigated through this. That one thing of just saying okay, I'm going to listen to this person. That is why or where our effectiveness comes in. We come in as a guide through the storm. I could not have done it without having somebody there. When I was, nine years ago when I started this whole recovery process, I did not think it would ever work. I never thought I would be on the side and turn around and reaching back and saying follow me through the storm brother. I got you. When somebody says I got you, there is nothing more powerful than that. There is nothing more relieving than that is the fact that somebody says I got you. Follow me through the storm. That is when things started to come to life. That is when life started to happen again. That is the effectiveness when somebody turns around and says I got you. Nine years ago, I never thought I would be on the side. I didn't think I would be sitting in my own apartment again. I was homeless, jobless, hopeless, and I was lost. Without somebody who's gone through it, there is nothing that I could have done to get myself out of the storm. I actually needed to have somebody guide me through that. When you show up every day and say I need help, it is good to have somebody there who has been through that got help. That is where the healing starts; it is when it works. That is what

we as peer support specialists through our training in lived experience can turn around and say this is how it works and this is how you have to work it and you have to work every day. I told my patients all the time that Rome was not built in a day but you can be darn sure that they laid brick every day to make sure that it happened. There is a process to this. Having somebody who has gone through this process is what helped me understand that the process works and it works if you work it. It works if you listen. The peer can help with that. They can sometimes pull the person through there, and that is where it happens. We work worth the counselor and with the doctor and everybody else to bring it all together in a little ball to say here is how it works and this is how we are altogether helping. You don't understand that until you have somebody who's gone through and said here is how it works and here is why it works and here is where the healing is going to start. Trust me brother because it is going to happen. If you do not trust somebody, at least trust what I am saying. That is where I got it. Nine years later, I could not have done it without anybody else. You cannot do this alone. As Sloane said earlier, it just takes that one person to say go do this. She had to go away from what she knew and that comfort zone because when you become that storm it is dangerous and terrible and homeless and hungry but it is your comfort zone and you make it to where that is all, you know, and that is where the comfort is. Now you're telling me this is uncomfortable and now I have to go off and do this? What the hell are you talking about? When you can start getting them to leave that bad comfort zone and into an actual zone of hope and healing, that is where they start to get it. That is where the person struggling with the addiction, the struggle becomes less and less. The more you show and listen to somebody like Samson or somebody or the counselor's in Glenallen where I work, they are wonderful people and they have all this knowledge and you can see the frustration. They come to me and say Will, can you talk to this person I think you guys have a connection and we work as a team to work and move forward and we try so hard to make it that way I cannot express I get worked up and I lose my thought, but at the same time I am so excited over the fact that we can do so much good when we work together as a team and that is what all comes together. I never thought that life could be this great and that is because of the fact that folks are sitting there and willing to go and people like NAADAC is saying we want to help and we are

all going to get better helping because that's why we get into this. We get into this to help other people. We come out of ourselves and give ourselves to somebody else and when you have a peer there and you get this pushback from the patient, you know, saying what do you know. You haven't been there. And I am like I have been there. You take some of those pushback's don't work sometimes and then they start to listen and then they start to understand that when you get the patient to start to believe like I believed that is when all comes together and we can see the success stories today today had the pleasure of seeing somebody's last step to step down off of methadone dose and he moved on and he was bawling and crying and happy and we hugged it out and high-fived and his mom was there and that is the exact reason we do this so that these people can move forward and live life again. The life that they are living in right now is so chaotic and horrible and I have been there and it sucks. And I know better. I know better now and I went to pull everybody forward by working together. I am rambling on right now because I feel so passionate about this. If I can and still just a fraction of the passionate somebody else and that one person can do it then this is why I do this. This is why I lay awake at night saying how am I going to help this person. I got this idea and Samson I am right there with you. I read those articles and I get those and I pass it on and I get all this information and pass it on. If I don't give away what was given to me then I am just being selfish and that is not the way to live anymore. When you can get somebody in there and the MAT consent and everybody works with that stigma and you can say know that is not a stigma. If you can take away the fear of withdrawal there is a friend of mine who said he could not go through the withdrawal so he went back out and he did not make it. He is dead. If I can take away that fear and get the cloud of doubt away then that is where the MAT comes in. You can take away that fear of withdrawal and that we give them the knowledge of long-term recovery because long-term recovery is the ultimate solution. I didn't realize that nine and a half years ago, but today it is something that I'm going to throw at people. The big unit pitching at the World Series. I'm going to throw that heater and you're going to knock it out of the park. Thank you all for letting me talk here. And I'm sorry for rambling but I get passionate and that's the way it works.

SAMSON TEKLEMARIAM: Ramble on. This is exactly what we are talking about. If you go to behavioral health group's website, we dare to say this statement. If you go to BHG recovery.com we say that this is real recovery. Do understand the authenticity of what we are talking about. Real recovery is not just this one entity that we are hoping and trusting. Sometimes that works for some folks. We have been saying for decades that there are multiple paths to recovery but do we really believe it? Folks like Will and Sloane he got me stirred up. These stories and passion and integrity of not just saving themselves, but also reaching back to save somebody else that is something that we can no longer survive in this industry without. We are at a point now where we have to have peers. This is a critical moment. My hope is that the passion that Will shared the passion that Sloane shared can create a contagious vibe. We want that authenticity you may not believe that you're going to have time for Q&A. I'm going to knock this out pretty quickly.

Maury, feel free to join back in. I want to know from you all. What did we miss? Share with us in the chat box. Here are the key value adds that we have patient overload, help with care coordination, missed appointments, grant assessment, peer recovery led groups, yes. And train peers can train staff. What? Maury opened my eyes to this, but having peers speak to your staff and team Maury do you want to share anything more about these value adds?

MAURY LONG: They are training our counselors and bringing to light the barriers that sometimes counselors never see and they have no understanding. They helped me honestly. The peers have a closer bond to our patients than counselors. Because they have that bond they are able to train and share and bring insight. They are the gateway to our centers, they are our eyes and ears, but they are so much more. They bring so much value to our team. There is no way, it is impossible to do this without peers. Since we brought them on, it is a night and day difference. Patients look for them. It is ironic but I don't think it is a coincidence that patients will come and find their peers first before they find their counselor. They will share information with a peer before they find Nancy with the LPC or the doctor is amazing and is such a vital asset.

SAMSON TEKLEMARIAM: That is great, the peers are our greatest ally. Option B. most of us the option in the polling question earlier. This last checkpoint is super

valuable. Peers allow counselors to function at the highest level of their licensure. Have you been in this field for a few years and feel like you aren't doing counseling? Maybe it is because you are wearing so many hats in the hat of a character of a legal liaison, coordinator, parole officers call buddy, you are wearing all these other hats that have nothing to do with your clinical work. You are not working at the highest level of your licensure because you do not have peers in your program supporting the clinical environment, supporting the framework of care. I love these ideas that you are dropping in here. I'm going to go ahead -- Maury.

MAURY LONG: We have a counselor that is recovered . She is now worked her way to a counselor. She is by far, I have 12 centers throughout the state of Alabama. She is by far the most successful life-changing counselor that we have. As a matter of fact I have her for every counselor who walks in the building every new counselor they spend five minutes a day with this counselor. She tells them that this is how you view life from our patients perspective. She trains our team, our new team members and all team members what to look for, what to expect if patients act out in this way, how to engage direct divert and get back on track. Because she has lived it. I am fortunate and even say blessed enough to have this double fold in our facility.

SAMSON TEKLEMARIAM: I love that. That let's earn peers know to keep growing. To get that next level licensure. In four minutes or less, I'm going to give it to all short and simple on how to fund and recruit and incorporate peers. I would love Maury to share one example of how he brought this to me and our Alabama programs and help me push the vision throughout our company since I've met Maury started working with him I felt spread this idea of recruiting peers we now have within the last 60 months hired up to 40 peers in 20 states. We're going to keep growing to keep these positions open and keep recruiting. Start with the local ROSC or RCO.

Stay connected with your state authority, state SAMHSA or HRSA, connect with your addiction Association or affiliate in your state, connect with advocacy. NAADAC has their advocacy conference in April. If it's not growing and getting adequate funding. Integrate peers into billing codes and higher than full-time or part-time eventually you can look at sustainable methods like H0038 that is directly from the Medicaid behavioral

health billing manual for peer support recovery services. This is a sustainable part of your workforce. Maury has a sustainable story that you can that Maury can share.
MAURY LONG: Years ago with Alabama, Alabama, Department of behavior health we had a quarterly meeting were all the providers in the state would come in the state would give us a different format of speaking and there was a particular event early on in her name is Ms. Pam Butler and she spoke about peers and what they do throughout the state of Alabama. It blew my mind. At the time, I don't even think we had a peer there. To hear her talk about what peers can do and what they do in the communities, it blew my mind. What I saw within our facilities, I saw counselors who had no empathy toward patients. I saw counselors who were punitive toward patients. I saw counselors who had no patience for patients within our facility and when Pam was talking the lights went off. That was the answer that was how we bridge the gap to bring somebody who has lived it knows and understands it to our world and all the while I'm thinking we can train them and interact in my wheels are turning. After the conversation I reached out to Pam and she started providing peers through a program called ROSC. Every time we grew, I got a pier. Pam and I partnered together. And she would help me find peers in the community as well as finding peers within our own organization to train and become certified to be peer recovery specialists throughout our centers. Long story short, I have now worked with Pam to the point where we have hired those peers and they work with BHT and she has been Pam Butler as well as the peers, once they came on board, the patient's lives changed overnight. As we incorporated them into the things we do every single day.
SAMSON TEKLEMARIAM: Just to wrap it all up. What is a ROSC? A recovery-oriented system of care supports a dispersant center and builds on the strength and resilience of families individuals to achieve abstinence and improve wellness wellness and quality of life for those who are at risk of alcohol and drug problems. Our CO is a full nonprofit organization. In some states they are funded directly as a part of health and human services HHS. Texas is a wonderful example. They mobilize resources within and outside the recovery community. These organizations are staffed, run and led by peers. I'm going to post on Maury as the regional director of Alabama behavioral health group. Great leaders are known as people who know how to research and

understand and leverage the resources. Notice the story you shared. He remembers her name is set in the Department of behavioral health meeting and he is getting infected and staying connected. It's not about having all the answers. It's about having the passion and compassion to keep your ears open to keep her neck stretched out, always looking for leaders not knowing is no longer an excuse so here let me equip you all even more so to have to go too far into it. I'm dropping a resource into the chat box that you all can have and I will send this to NAADAC. This is the Peer Recovery Center of Excellence if you're struggling with how to implement peers into your program, this is a grant funded organization paid for with tax dollars designed specifically to walk you through that process. It is housed at the University of Missouri Kansas City and they have tons of remote workers and support in many, many different states. They partner with several different national councils Association's research universities and most of the research we presented today has come from them.

While Medicaid does have some funding for peer services in many states, we still have a lot of work to grow. Sustainable funding is still an issue. Want to talk about the integrated care system. We have some ideas for the most important thing is that we are integrating peers into your workforce to refrain from siloing. Take a look at this checklist. I put up here on purpose because I knew we might want to breeze through this part. The most important thing is to integrate them. Don't just bring them onboard and hope they figure it out. Integrate them into their program. If you don't know where to begin go to NAADAC's website and hover over free webinars. There is a free series on peer recovery support and actually covers how to hire and manage great leaders and how to leverage the resources. What is the holdup? Ensure that there is leadership buy-in and they are incorporated into every single function of your program. This is a short sample onboarding planned. I'm going to drop this link also in the chat box. If you want to know more about behavioral health group at some of the research presented today, some of the data points, a few more citations are in this link. You can hold your phone up and get that QR code and download the white paper. Or you can go to the link that is in the chat box. I'm going to open this up for questions from NAADAC. Sloane, you can also rejoin us on camera. We can see if we can squeeze in one maybe two questions.

HALEY HARTLE: That was wonderful. Thank you so much. The chat was constantly going the whole time, which was awesome to watch. We have quite a few questions, but one that was pumped up to the top was from Katie and the question was how can we move the dial of acceptance of MAT when our justice system and recovery court do not allow participants and detention residents to be on MAT? I am struggling to "keep my cool" with the misinformation misperceptions that I am hearing.

SAMSON TEKLEMARIAM: I will say criminal justice is a tough place. There is the appearance of rigidity but the honest truth is that is also the place that has seen the most change. There are open slots for rehabilitation or for recovery mindsets. This is a paradigm shift. As you are coming into an environment rigid and it seems like there is a lot of stigma and closed doors but the truth is advocacy. You have to wear the hat of advocacy. Some of that is constantly educating those in the criminal justice system on other ways to do things but you may also kind of be okay with the status quo and create some workarounds in your program so you have connection points. If somebody is being incarcerated for a nonviolent crime, how can we advocate for that person to get treatment? How can we advocate for them to get prescriptions in prisons? This is another issue is getting MAT and prison settings. We have eight states so far in the country that have allowed that and even those that there is a tremendous amount of hoops for people to jump through. Others?

MAURY LONG: We deal with that a lot Alabama being a Bible state. They look at people make it as a poor decision versus an actual addiction and disease. Some things we have done. The laws are changing of the staff's are there. Some of the things we had to do with us we invite them to come to our location centers and we kept knocking and chipping away whether it was lawyers who represent patients who have to go to the systems. The more outreach we have done in the more time has passed, the more change we are saying. They are willing to allow us to get in the door. Don't quit. Keep knocking and keep going out and keep doing outreach. Cops would park across the street from our centers across the street is a form of intimidation to our patients. We did our due diligence they said they had the right to park where they wanted to but because they began to see the changes they begin to see those patients not going back into the systems. We even challenged our patients to not go to jail. We challenged our patients

to not do those things that would bring a negative light to all the change in positivity they were doing. Change comes slowly sometimes and some people have a certain mindset of what we doing, but I would say to be diligent. It is frustrating. I live it. It is frustrating and challenging, but you have to stay the course and remain positive. If you lose hope, so do patients. If we lose faith, so do patients. Continue to advocate for those patients and continue to be that safe haven to speak up for them. I've come to centers and cops would show up we have it handled thank you. And send them on their way. You have to continue to be an advocate for them. Patients are protected by law. Some people do not know that. Patients are protected by law if they have a mental illness. They are protected by law. Know your rights and learn those things.

HALEY HARTLE: That is wonderful. Thank you for your insight on that. Unfortunately, we only did have time for the one question, but all of the other ones that were not answered, we'll set aside and send those to the presenters and then we will have those answers posted soon on the NAADAC website. We have a few more housekeeping things to go through really quickly. I will pull this up. This is a reminder of where you can find the CE instructions for the CE quiz. You can access the instructions for that on the web page as well. Here are some of our upcoming webinars. Our next one is February 23rd, The Connection Between Substance Use and Human Trafficking with Claire Openshaw. Our women specialty series is also beginning next month.

We do have some on-demand specialty online trainings as well that you guys can access on our website. Those are six to seven webinars on a particular topic and then you can receive a certificate for completing all of those together.

A few of the member benefits of joining NAADAC. You do have access to more than 320 CEs just like today's content. Just a reminder that you can join for more access to those. All education is free to professionals but there are costs associated for the CE exams for nonmembers. So you would get those for free as well. We thank you guys so much. Thank you all of your presenters for being here. That was wonderful and was such good insight and information. Then just a reminder, if you are a social worker, if you can stick around for another minute or two, we have a short video on how to add your license number to your CE. I will play that now. Otherwise we'll see you guys on the next webinar. Thank you for watching.

(Video playing)
-- our association management software. You only need to do this one time. After that, the system will be set to pull your license number into your certificate for completion after you attend a NAADAC webinar for training. You can see that the first step is to log in to your member account. Once you are logged in you want to go to my profile right here in the lower-left corner. Ensure that you have selected the account in the account tab and then arrow down and select additional as you can see on my screen. Next to the right select the licenses tab. It is set up here as you can see and then click add new license.
Here is where you want to pay attention: You want to make sure under license type that you select social work license in this field. This is what is going to tell the system to put your license number into the certificate. You want to make sure you get that right. Is required that you enter the state as I am doing here as well as your license number that is going on the certificate. The rest is optional but feel free to put that in so that the system has it recorded for you. Once you have all the information in there, you're going to go ahead and hit save.
If you have another credential or certification that you want to add into the system, you can go ahead and do that. You just want to ensure that at the top of your license type you select state certification license or accreditation and then fill out the rest of the information. You only want to have one license type with social work license. And that is that. You are all set up and your CE certificates now include your license number as required in many states and jurisdictions.
HALEY HARTLE: All right. Thank you all so much for sticking around for that. And I hope you have a great rest of your afternoon. Bye.
(CONCLUDED AT 4:34 PM)