

EQUIPPING BEHAVIORAL HEALTH
SYSTEMS & AUTHORITIES TO
PROMOTE PEER SPECIALIST/PEER
RECOVERY COACHING SERVICES



BRINGING RECOVERY SUPPORTS TO SCALE
Technical Assistance Center Strategy (BRSS TACS)

Expert Panel Meeting Report
March 21 – 22, 2012

PREPARED FOR THE SUBSTANCE ABUSE &
MENTAL HEALTH SERVICES ADMINISTRATION

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TABLE OF CONTENTS

Acknowledgements	3
Disclaimer	3
Public Domain Notice	3
Originating Office.....	3
About BRSS TACS	4
Background.....	4
Context for the Expert Panel	4
Challenges Experienced by Peers in the Workforce.....	5
Challenges Experienced by Behavioral Health Programs.....	7
Challenges Experienced by Peer-Run Programs	7
Challenges Affecting Behavioral Health Systems & Authorities.....	8
Challenges Related to the Evidence Base for Peer-Delivered Services	8
Meeting of the Expert Panel.....	9
Questions Considered by the Expert Panel	9
Theme One: Changing Tides of Support.....	9
Theme Two: Understanding the Research	10
Theme Three: Workforce Dimensions	11
Theme Four: State Models of Peer Support/Recovery Coaching.....	14
Future Directions & Recommendations.....	16
Conclusion.....	18
References	19
<i>Appendix 1: Commonly Used Terms.....</i>	<i>21</i>
<i>Appendix 2: Expert Panel Participants</i>	<i>22</i>
Panelists:	22
Expert Panel Facilitators	24
Center for Social Innovation Staff	34
<i>Appendix 3: Meeting Agenda</i>	<i>25</i>



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DISCLAIMER

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ORIGINATING OFFICE

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ABOUT BRSS TACS

In September 2011, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded the Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) contract to the Center for Social Innovation (C4). The funding award, through C4 and its partners, establishes the BRSS TACS Team, a consortium dedicated to promoting wide-scale adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental health conditions. The BRSS TACS team includes:

- ◆ Abt Associates
- ◆ Advocates for Human Potential
- ◆ Boston University Center for Psychiatric Rehabilitation
- ◆ Faces and Voices of Recovery
- ◆ JBS International
- ◆ National Coalition for Mental Health Recovery
- ◆ National Federation of Families for Children's Mental Health
- ◆ National Association of State Alcohol and Drug Abuse Directors
- ◆ National Association of State Mental Health Program Directors
- ◆ New York Association of Psychiatric Rehabilitation Services
- ◆ Pat Deegan Associates

BRSS TACS encourages and supports the widespread adoption of recovery-oriented services and systems of care across the United States. BRSS TACS serves as a coordinated effort to bring recovery to scale, leveraging past and current accomplishments by SAMHSA and others in the behavioral health field. These efforts are an important mechanism for coordinating and implementing SAMHSA's Recovery Support Strategic Initiative. Through the Recovery Support Strategic Initiative and other efforts, SAMHSA supports a high quality, self-directed, and satisfying life in the community for all people in recovery, and includes health, home, purpose, and community.

Background

Behavioral health systems and authorities are striving to become more recovery-oriented by delivering strength-based, holistic services that enhance recovery opportunities for people with behavioral health conditions. Integration of peer specialists and peer recovery coaches into the recovery workforce is a critical component to recovery-oriented service and systems. Services provided by peers are a vital link

between systems that treat mental health and/or substance use conditions in a clinical setting and the larger communities in which people are seeking to achieve and sustain a meaningful life.

With implementation of health reform, peer recovery support services are expected to be in much greater demand. These services are likely to be delivered in an expanding variety of settings, including hospital emergency departments; primary care practices; person-centered health homes; federally qualified health centers; accountable care organizations; community-based alternatives to jails and prisons; high schools and colleges; veterans' centers; homeless programs; and others. Capacity building is needed to further develop peer specialists and peer recovery coaching services as a component of the recovery workforce. Behavioral health systems and authorities have an important role to play in supporting the development and expansion of this element in the workforce (see Appendix 1 for definitions of terms used in this report).

Through the Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) project, SAMHSA convened an Expert Panel on March 21 – 22, 2012, to learn more about the needs of behavioral health systems and authorities as they strive to promote and support peer services, and to strategize innovative responses to those needs. Specifically, the Expert Panel members worked to:

- ◆ Understand current practices, implementation strategies, and contexts for peer specialists/peer recovery coaches
- ◆ Identify innovative workforce development activities and summarize workforce development needs to implement peer specialist/peer recovery coaching services
- ◆ Develop specific recommendations for behavioral health systems and authorities as they seek to support and implement peer specialists/peer recovery coaches across a diverse range of settings

Context for the Expert Panel

In a departure from traditional mental health services, today peer specialists and recovery coaches play essential roles in a wide range of service environments. While their job descriptions are largely dependent on the setting in which they are employed (e.g., state hospitals, community behavioral health centers, peer-run recovery centers), their approach entails a fresh, more participatory role for people in recovery as well as the opportunity to advocate for and support their peers.

A growing body of evidence suggests that peer-provided, re-

covery-oriented behavioral health services produce outcomes as good as—and in some cases superior to—services from non-peer professionals (Solomon, 2004). The use of peer specialists as part of the treatment team, for example, has been shown to have favorable results (Davidson et al., 2006), and when peers are part of hospital-based care, the “results indicate shortened lengths of stays, decreased frequency of admissions, and a subsequent reduction in overall treatment costs” (Chinman et al., 2001). Other studies suggest that using peer recovery coaches can strengthen social supports and improve recovery outcomes (Kaplan, 2008).

A primary difference in this approach is that peers use their lived experience and experiential knowledge to help others. Many in the behavioral health field now recognize the unique contributions that those with lived experience of mental health problems and addictions can make to another person’s recovery process. The transformational changes necessary to develop recovery-oriented behavioral health services and systems, however, compel the field to formulate ways in which

peers contribute to the systems’ overall missions of helping people lead meaningful lives in the community and to develop effective program practices and systematic strategies to support peers in the workforce. The work of this expert panel summarized and advanced the understanding of what the behavioral health field needs to do to in order to successfully promote peers in the workforce.

Challenges Experienced by Peers in the Workforce

While many view peer specialists and recovery coaches as critical components of recovery-oriented systems, the roles are relatively new additions to the behavioral health workforce. With the novelty of peer roles in the behavioral health workforce, there are basic questions about how to define these roles. In other words, what defines the “peer-ness” of the role? There are other uncertainties about how best to prepare people in recovery for the role of peer, how to prepare and support programs to incorporate peers in their services,

TABLE 1. PEER SPECIALIST/RECOVERY COACH ROLE

Is/Does	Is Not/Does Not
A person in recovery	A professional
Shares lived experience	Gives professional advice
A role model	An expert or authority figure
Sees the person as a whole person in the context of the person’s roles, family, community	Sees the person as a case or diagnosis
Motivates through hope and inspiration	Motivates through fear of negative consequences
Supports many pathways to recovery	Prescribes one specific pathway to recovery
Functions as an advocate for the person in recovery, both within and outside of the program	Represent perspective of the program
Teaches the person how to accomplish daily tasks	Does tasks for the person
Teaches how to acquire needed resources, including money	Gives resources and money to the person
Helps the person find basic necessities	Provides basic necessities such as a place to live
Uses language based on common experiences	Uses clinical language
Helps the person find professional services from lawyers, doctors, psychologists, financial advisers	Provides professional services
Shares knowledge of local resources	Provides case management services
Encourages, supports, praises	Diagnoses, assesses, treats
Helps to set personal goals	Mandates tasks and behaviors
A role model for positive recovery behaviors	Tells person how to lead his/her life in recovery
Provides peer support services	Does whatever the program insists he/she do

and how to assist systems and authorities to adjust organizational structures and financing to support peer roles.

Based on mutual support, mutual learning, and mutual responsibility, the peer role differs from the professional role in the behavioral health workforce (Mead & MacNeil, 2006). A peer is a person who has lived experience of recovery from mental illness and/or addiction and who wishes to provide peer support services to others who are living with these disorders. Discussions in both the mental health and addiction fields address who qualifies as a peer and what personal experiences are required to make someone a peer.

Is it critical, for instance, that a peer has experienced hospitalization or detoxification? Homelessness? Incarceration? Use of narcotics? How “recovered” must the peer be to qualify as a peer specialist or recovery coach? There are endless varieties of experiences that could serve as peer credentials. Despite these ongoing debates on how to define a peer, some points of consensus have emerged among peers and programs that offer peer services and support:

- ◆ A peer is a peer when he/she self-identifies as a peer and is willing to share his/her lived experiences with others
- ◆ Peer support services should strive to recruit a diverse cadre of peers so that people with a range of backgrounds and experiences might find the possibility of connection
- ◆ Peers/coaches may be volunteers or paid for their work

One definition of peer support seems relevant to both the mental health and addiction fields:

Peer support is the process of giving and receiving encouragement and assistance to achieve long-term recovery. Peers offer emotional support, share knowledge, teach skills, provide practical assistance, and connect people with resources, opportunities, communities of support, and other people. (Mead, 2003; Solomon, 2004)

Another description suggests that “[P]eer support is based on the belief that people who have faced, endured, and overcome adversity can offer useful support, encouragement, hope, and perhaps mentorship to others facing similar situations” (Davidson, Chinman, Sells, & Rowe, 2006, pg. 443).

Peer support services are described as being non-clinical and recovery-focused (White, 2006). “Non-clinical” refers to the fact that peers do not offer professional services, make assessments, or dispense expert opinions. There is not a power differential in the relationship—or, if there is one, it

is diminished compared to the customary professional-client relationship. “Recovery-focused” means that peer support services target recovery outcomes such as improved health and wellness, an increased sense of self-efficacy or empowerment, and increased success and satisfaction in a range of community settings such as work, home, and school, instead of merely focusing on symptom reduction. Peers/coaches are strengths-based and focus on the relationship that they have with the person striving to achieve recovery (Mead, 2003; White, 2006).

Peers increase their knowledge of the critical and unique contributions of peer support through training, and the behavioral health system supports these valuable roles through well-designed programs and supervision. Lack of training and lack of peer-focused supervision and support can create confusion in the workplace because the staff is unclear about the peer’s role in the workplace. These work conditions lead to a phenomenon that peers experience when they “drift” toward professionalization and thus lose their “peer-ness” (Kaplan, 2008). Peers find that when their roles are undervalued and unsupported by program structures and supervision, their tendency is to begin identifying with professionals in the program. When peers are educated about the principles and values of peer support services, trained in their vocation’s core-competencies, and have program support, they are able to stay faithful to and engaged in their peer roles.

Some peers express concern about the lack of a clear job description and being required to perform tasks that have little to do with providing peer support. Some programs have hired peers to perform functions that other staff find time-consuming or unrewarding such as driving, cleaning, cooking, or accompanying people to appointments. While a peer may perform any or all of these tasks, they are done in partnership with the program participant and with the intent of strengthening the relationship and modeling recovery behaviors.

Because of the lack of clear job descriptions and expectations, peers may have difficulty evaluating their own success in performing their jobs. The lack of consensus about peers’ core competencies combined with unclear or unsuitable job descriptions leaves peers uncertain about their own job performance. Furthermore, many peer specialists/recovery coaches are concerned about the lack of supervision, or supervision that does not match their role. More senior peers rarely supervise peer staff, and non-peer supervisors may lack a clear enough understanding of the role to provide accurate feedback and pertinent support.

Among the major concerns for peers are low—or no—pay and a lack of career advancement opportunities. For peers who work as peer specialists, recovery coaches or in other peer roles, there are few, if any, opportunities for promotion. As a result, some peers have abandoned the peer role, obtained a professional credential, and begun working in another role within the behavioral health field. Although this may be a viable career path for some, it is an undesirable solution for those wishing to retain the peer role. While some agencies have found solutions to this dilemma by creating positions and providing training to peers who wish to become supervisors and managers, other programs have not been able to respond in this way. In a recent survey of peer specialists in the mental health field, low pay and lack of career advancement opportunities was the number one reason that people left their jobs (Harrington, 2010).

Challenges Experienced by Behavioral Health Programs

Many behavioral health programs face challenges as they make efforts to incorporate peer specialists/recovery coaches. These challenges can be categorized as problems with program's culture, commitment, and/or capacity (Farkas, Ashcraft, & Anthony, 2008). Program culture—or “the way things are done around here”—provides the foundation for all program activities. Programs that make good use of peer support often demonstrate a culture that embraces a recovery-orientation, fosters collaborative relationships among staff and program participants, and strives to be a learning community (Farkas, Ashcraft, & Anthony, 2008). Some programs have difficulty implementing peer support/recovery coaching because their culture lacks flexibility and the ability to adapt to necessary changes. The program's culture is often a reflection of its values and mission, and it affects every person in the program, from its leadership to those who participate in services.

A program's organizational readiness to integrate peer specialists/recovery coaches depends in large part on the strength of its recovery-orientation. Programs that have not made progress in incorporating a recovery vision may not have the attitudinal and structural supports to successfully employ peers/coaches in their workplace. Programs likely to be successful in implementing peer support/recovery coaching have strong recovery values and principles that guide their service delivery. The program has a conceptual and policy framework based on the vision of recovery that operationalizes the vision (Davidson et al., 2007).

Implementing peer support/recovery coach services requires a strong program commitment. Commitment translates into the dedication of key personnel, including both formal and informal leaders within the organization to do the work necessary to implement peer-provided recovery services. Without such a commitment, programs are unlikely to create the organizational transformation necessary to support peer specialist/recovery coach roles. Commitment is seen when program staff, peers, and participants work together to bring about needed changes in the program. Without a strong commitment, some programs experience conflict between staff and peers/coaches, high rates of job dissatisfaction, and lackluster outcomes.

Program capacity refers to knowledge and skills relative to peer support/recovery coaching services. Some programs lack a clear understanding of the peer/coach role, or fail to recognize the benefits of peer specialist/recovery coaching services. Programs that lack capacity for the successful implementation of peer support/recovery coaching experience many unforeseen problems. For example, some programs that did not create appropriate job descriptions for peers/coaches have grappled with the question of appropriate job tasks for peers/coaches. Most programs report that they struggle with a lack of knowledge about how programs can best integrate peers into their workforce and culture. Capacity building is an ongoing challenge for behavioral health programs. Successful programs develop capacity over time.

Challenges Experienced by Peer-run Programs

Peer-run programs encounter challenges with delivering peer services as well, and these difficulties also fall into categories of culture, commitment, and/or capacity. Although recovery centers and other peer programs are likely to have a strong recovery-orientation, they may lack the necessary infrastructure and skills to establish policies and procedures that support peers in their jobs. Their culture may not have the quality of accountability, thus posing a challenge to long-term survival.

Lack of commitment may present challenges to peer-run programs. Most, though not all, peers work part-time or on a voluntary basis. They are not paid to do many of the tasks necessary for program growth and survival. Peer leaders may experience burnout because they lack sufficient support from other peers in the program. The need to “grow” peer leaders is an ongoing pressure for peer-run programs. Sometimes what seems like a lack of commitment is a reflection of the lack of capacity. Peers/coaches may not have the knowledge and skills needed to run a program. Dozens of skills are criti-

cal to administer behavioral health programs, and if peers lack the skills in-house and few administrative supports exist, then the program will not flourish.

Peer-run program administrators are challenged with the difficulty in developing infrastructure for their program's continuity and growth. They lament that there is no funding to support activities such as creating policies and procedures that facilitate a more manageable workflow. Peer leaders have had to develop competence in a broad range of managerial and leadership skills in order for their programs to survive.

Challenges Affecting Behavioral Health Systems and Authorities

Behavioral health systems and authorities have many questions about how to adopt and support peer specialists/recovery coaches. Issues of particular concern are how to finance peer services and how to address peer certification. Behavioral health systems and authorities generally understand that not every solution or strategy will fit the needs of every program. Additionally, these systems and authorities have limited financial resources and cannot fund all the services and supports they would like to have in their service systems. With finite resources, leaders find that they have to make difficult decisions that are bound to be unpopular with some constituents. For example, many behavioral health systems and authorities grapple with the issue of where to put limited peer support/recovery coaching resources—in a recovery center or spread throughout the system—because they cannot adequately fund both approaches.

Challenges Related to the Evidence Base for Peer-Delivered Services

Despite the proliferation of peer-provided services in the mental health and addiction fields, lack of an accepted typology hinders research and evaluation of peer services. The

literature that does exist tends to be descriptive and lacks experimental rigor (Davidson et al., 1999; Rogers et al., 2009). Although several experimental studies have suggested that peers can deliver case management and support services as well as professionals can (Chinman et al., 2000; Solomon & Draine, 1996; Solomon, Draine, & Delaney, 1995), it is hard to characterize the specific benefits of peer support.

One large multisite study of consumer-operated services found that people diagnosed with mental illness who were randomly assigned to participate in peer support services showed greater improvement in well being (i.e., a composite construct that combines social inclusion, empowerment, quality of life, and hopefulness) than people who participated only in mental health services (Campbell, 2004). Another long-term study of the effects of participation in a peer support program for people with co-occurring disorders found that participants experienced fewer and briefer hospitalizations than people in a comparison group who did not participate (Min, Whitecraft, Rothbard, & Saltzer, 2007). With the wide range of interventions, program models, and settings, much is yet to be known about peer support from a research perspective. Random assignment to peer services, the gold standard of research design, may conflict with the principle that peer services need to be voluntary. As programs and systems integrate peer supports, it becomes increasingly important to conduct program evaluations and research trials to gather evidence on the benefits for people in recovery. Furthermore, funders and policymakers are interested in the cost effectiveness of peer-provided services. Evaluation questions need to be answered about the program structures, types and styles of supervision, mentoring, and supports that help peers experience job success and role satisfaction. As more peers enter the workforce, the training programs that prepare peer specialists and recovery coaches for their jobs need to be evaluated for their results and impact on the behavioral health field.

MEETING OF THE EXPERT PANEL

SAMHSA's Expert Panel on Equipping Behavioral Health Systems and Authorities to Promote Peer Specialists and Peer Recovery Coaching Services met at the SAMHSA offices in Rockville, Maryland, on March 20 – 21, 2012.

The 14 panel members represented a wide range of expertise and perspectives. They represented different geographic areas of the United States (urban and rural), different roles (i.e., research, State systems, workforce development, providers, peers), as well as different systems and settings (i.e., mental health, substance use disorders, or both). Several panelists fulfilled multiple roles (see Appendix 2 for a list of panel participants and discussion facilitators).

The panel's overarching goal was to understand the needs of behavioral health systems and authorities as they promote and support peer specialist/peer recovery coaching services and to strategize innovative responses to those needs. Specifically, the panelists worked to:

1. Understand the current practices, implementation strategies, and contexts for peer specialists/peer recovery coaches
2. Identify innovative workforce development activities and summarize workforce development needs to implement peer specialist/peer recovery coaching services
3. Develop specific recommendations for behavioral health systems and authorities as they seek to support and implement peer specialists/peer recovery coaches across a diverse range of settings

QUESTIONS CONSIDERED BY THE EXPERT PANEL

- ◆ What is already working to promote peer specialists/recovery coaches?
- ◆ What challenges prevent behavioral health systems and authorities from implementing peer support/peer recovery coaching services?
- ◆ What creative strategies have been employed to overcome these challenges?
- ◆ What is the current state of research on peer specialists/recovery coaches?
- ◆ What are the gaps in the current research?
- ◆ What are recommendations for new directions in research on peer specialists/peer recovery coaches?
- ◆ What new concepts and/or service settings are implementing peer recovery coaching?

- ◆ How are States, authorities, and programs funding or supporting these new efforts?
- ◆ What are the major challenges that face the peer workforce such as recruitment, retention, training, and supervision?
- ◆ What is the role of peers in health care, criminal justice, or other settings?
- ◆ What tools and strategies are programs using to support workforce development?
- ◆ What can behavioral health systems and authorities do to support workforce development activities?
- ◆ What makes a peer specialist/recovery coach different from any other worker in the behavioral health system?
- ◆ What are recommendations to promote programmatic and workforce development among behavioral health authorities?

The meeting agenda was organized around the three overarching goals outlined above and included presentations, large group discussions, small discussion groups, and reports from the groups (see Appendix 3 for the meeting agenda). This format enabled each panelist to speak on a wide range of issues while allowing more focused discussions within the small groups.

Before the meeting, each panelist read a background paper to ensure that he/she was familiar with a range of issues and not only those directly affecting their own work. Over the course of the two-days, nine panelists gave brief presentations that focused on the meeting's different themes. Both large and small group discussions followed these presentations.

Theme One:

CHANGING TIDES OF SUPPORT FOR PEER SPECIALISTS/PEER RECOVERY COACHES

There is much excitement surrounding the general growth of peer-provided services and supports in the behavioral health fields. The number of environments and the variety of roles for peers have increased. Table 2 lists the environments and roles filled by peers in the mental health and addiction fields.

People in recovery from mental illness and/or addiction are also returning to their communities and talking about their experiences with others who may be struggling with addiction or are family members of a person who is struggling. These peers may not be employed by a program but are delivering an important service to individuals and their families who may need to learn that recovery is possible and that there are resources in the community to help. Resources like mutual aid and self-help groups, such as 12-step programs, SMART Recovery, Women in Sobriety and others, provide

critical support outside of the formal behavioral health system.

TABLE 2. ENVIRONMENTS & ROLES FILLED BY PEERS

Peer roles in behavioral health	Peer role settings
Recovery coach	Hospitals
Peer support specialist	Detoxification clinics
Recovery support specialist	Emergency rooms
Wellness coach	Rehabilitation programs
Peer navigator	Residential support services
Peer health care navigator	Employment support services
Wellness coach	Community recovery centers
Peer advocate	Court diversion programs
Peer partner	Jails and prisons
Recovery partner	Home health services
Peer educator	Health care agencies
Peer care attendant	Churches

Peers are becoming more involved in helping people who are in the criminal justice system who may also have a mental health and/or substance use disorder. These peers are inspiring people who are incarcerated to believe that recovery is possible and that there is a community of people in recovery who can help when they leave jail or prison. Recovery Innovations, a behavioral health organization that has trained over 5,000 people across the country, recently developed a peer-training program in which they train peers while they are in prison and facilitate employment options for the peers following their release. They are currently training 89 peers in six different prisons. Peers are working in jails and prisons and are helping people with their re-entry into their home communities.

Peers with criminal histories experience barriers when they endeavor to take roles in the behavioral health workforce. There is a need to conduct a systematic scan of laws, policies, and practices that create barriers for people with criminal justice involvement and to develop strategies to overcome these barriers.

Peers are also being used to assist with the Screening, Brief Intervention, and Referral to Treatment (SBIRT) process in

emergency rooms and other healthcare settings that might administer the SBIRT. Peers can facilitate intervention and referral while establishing a relationship with the person in need of treatment. In primary care settings, peer services can be helpful in medication-assisted recovery for addiction. Some healthcare organizations use peer navigators, recovery allies, and health navigators.

Theme Two:

UNDERSTANDING THE RESEARCH

There have been at least three generations of research on peer support. The first focused on demonstrating the feasibility of peers providing support and other services within the behavioral health system. The second generation of studies showed that peer staff could produce equivalent outcomes to non-peers, and the third is investigating the unique contributions that peers make.

TABLE 3. EVIDENCE SUGGESTS THAT PEER SUPPORT & COACHING . . .

- ◆ Reduces the number of admissions and days spent in hospitals and increased time in the community
- ◆ Reduces use of acute services (e.g., emergency rooms, detoxification centers)
- ◆ Increases engagement in outpatient treatment
- ◆ Increases active involvement in care planning and self-care
- ◆ Improves social functioning
- ◆ Increased hope, quality of life, and satisfaction with life
- ◆ Reduces substance use
- ◆ Reduces depression and demoralization
- ◆ Improves chances for long-term recovery
- ◆ Increases rates of family reunification
- ◆ Reduces average service costs per person

While research highlights included the fact that mental health peer services are able to achieve outcomes beyond traditional services and that adding peer coaching and mentoring to substance use disorder services produces cost savings, there was strong agreement about the dearth of research on peer-provided services and supports, especially in the substance use disorder field. And while most behavioral health programs collect certain program evaluation data,

there are no consistent recovery-oriented measures that allow researchers and others to compare programs.

Panelists strongly agreed that data should be gathered and used to continually inform and improve services. They also discussed the fact that extensive programmatic evaluation data do exist and that these could be used to inform decision makers, but few programs have the resources to organize and analyze the data.

The panel identified various areas for additional research:

- ◆ Identifying indicators of job performance for peers/coaches
- ◆ Exploring data on justice involvement and recidivism after participating in peer services
- ◆ Cost effectiveness and cost benefits to behavioral health systems in terms of reduced use of high cost services as a result of offering peer services and supports
- ◆ Cost savings to SSI/SSDI as a result of peers being employed by the behavioral health care system
- ◆ Identifying the types and intensity of peer recovery supports along the continuum or stages of recovery
- ◆ Exploring the effects of peer services and supports on family health and functioning, the relationships among communities of color, other diverse communities, and communities of recovery

The panelists called upon SAMHSA to partner with the federal research institutes and fund research activities that would build an evidence base for peer support services across the fields of mental health, addiction, and health care. The spirit of the Expert Panel's message was to measure everything being done in the peer world and to find funding where it exists, and support evaluation as part of doing business.

Panelists discussed using evaluation and research to better understand implementation of peer services so that appropriate implementation strategies can be devised. The group identified various challenges to implementing peer services such as role confusion between peer and clinical providers, and staff resistance—and, at times, even staff hostility—toward peers and recovery coaches. Unequal treatment persists for peer staff including lower wages, lack of viable career options, and duties often relegated to unappealing tasks like driving and housework. Panelists endorsed evaluating the implementation process believing that the information learned would be helpful to bringing peer services to scale. Panelists recommended the following activities for new research directions:

- ◆ Create a Treatment Improvement Protocol (TIP) or similar document for recovery support services

- ◆ Understand the key indicators of peer support in order to foster replication across diverse settings
- ◆ Develop typologies of peer supports and establish level of evidence for each category
- ◆ Encourage scholarships to fund peers to conduct research
- ◆ Create surveys to collect data on how peer specialists and peer recovery coaches are doing in their jobs
- ◆ Study the effectiveness of peer services in new settings, including primary health care, criminal justice environments, schools, and others

Theme Three:

WORKFORCE DIMENSIONS

The third theme—peers in the behavioral health workforce—stimulated much discussion. Many issues and strategies were discussed, as well as the similarities and differences between the mental health and the addiction workforces. There was strong consensus that the number of roles, settings, and specialties for peers is increasing and that funding opportunities are expanding. While there was general agreement that many peers experience challenges in the workplace, there was some disagreement about how best to develop and sustain a competent peer workforce.

Misunderstanding and discrimination continue to be key challenges to integrating peers into the workforce. Providers, for example, may not understand the value of a peer workforce and recovery supports. The use and misuse of recovery language when identifying a peer as a person in recovery can pose a challenge, especially if staff members focus more on the person's recovery and less on his/her collegial role. Some peers report that they feel like they are under more intense scrutiny compared to their non-peer colleagues. Many peer specialists report not being respected for the unique contributions they make to a program, and some peers may drift toward professional roles leading to conflict with colleagues due to role competition.

Panelists discussed creative solutions that behavioral health systems and authorities could use to overcome these role-related challenges. The expert panel recommended that programs and providers in both the mental health and addiction fields use terms that all people can understand across the behavioral health and healthcare fields.

TRAINING & CERTIFICATION

Panelists discussed the differences between the training experiences of peers within the mental health system and recovery coaches within the addiction system. The mental health system has been training and certifying peer specialists since 2001. Thirty States recognize mental health peer

specialist training leading to certification. Generally, peer specialist training is funded by the mental health system, while the addictions field has little funding for the training of recovery coaches. Most, but not all, recovery coach training programs require trainees to fund their own training. Several agencies have secured funding from SAMHSA's Recovery Community Support Program (RCSP) and Access to Recovery (ATR) to provide training for recovery coaches and increase choices about services for people in recovery from substance use disorders.

The Illinois Department of Human Services' Division of Alcoholism and Substance Abuse and Governors State University's College of Health and Human Services Addictions Studies Program offers free training (one day per week for four weeks) focused on recovery coaching/mentoring as part of a recovery-oriented system of care for individuals and families dealing with substance use disorders.

The Recovery Coach Academy, operated by the Connecticut Community for Addiction Recovery (CCAR), is creating training to grant certification to recovery coaches. This training includes core competencies for recovery coaches with additional training on ethics, boundaries, medication-assisted treatment, gambling, and more. The basic 40-hour training requires an additional 20 hours of in-service training and passing an exam to become certified.

Although training programs for peer specialists in the mental health system have been around for over a decade, there have been no attempts to standardize models of training. To date, no national consensus defines standards for peer specialist/recovery coaching training programs. There have been efforts to define core competencies, but no national consensus exists. Training programs differ in length, ranging from 30 to 105 hours of face-to-face training. Certain programs offer web-based training in addition to the classroom. The Georgia Certified Peer Specialist Training Program was the earliest certified peer specialist training program in the country and the one that many other states use as a model. The Peer Employment Training program operated by Recovery Innovations of Arizona is an 80-hour program that has graduated over 600 students in the past four years (Katz & Salzer, 2006).

There is some agreement on the range of skills required to fill the role of peer support specialist or recovery coach. Initially, peers need training in core knowledge and skills for peer specialists/recovery coaches. Certain skills are generic and required for all: listening, showing empathy, sharing experi-

ences, inspiring or enhancing motivation, setting recovery goals, linking people to resources and services, teaching, giving feedback, setting boundaries, encouraging, praising, relapse planning, relapse intervention, collaborating with colleagues, and others (Gagne, 2009). Many peer specialists/recovery coaches may need training in computer use and record keeping in behavioral healthcare settings.

Peer specialists/recovery coaches working in specialty programs need advanced skills. Specialized skills vary by program but may include the skills and knowledge to teach healthy lifestyles and coping strategies, or to work with people who have serious physical health problems or criminal justice system involvement, or those who have experienced trauma (Gagne, 2009). Peer specialists/recovery coaches acquire advanced skills so that they have competency to lead groups, provide peer supervision, teach professionals, family members, and community members, or assume other leadership roles. Advanced skills can be acquired on the job or from training outside of work. Examples of advanced skills include providing strength-based supervision, conducting staff meetings, strategic planning, and leadership (Gagne, 2009).

Training programs vary greatly across the United States, and evaluation data are thin for most programs. Generally it is believed that peers should deliver the training and that there should be a focus on core competencies. Most peer specialist and recovery coach training includes an ethics component and features a peer code of ethics. Ideally, States would take a role in monitoring and evaluating peer specialist/recovery coach training programs. In States that have both certified peer specialist training and certified recovery coach training, the training resources are separate. There was discussion about the benefits of sharing training resources to maximize the number of peer specialists/recovery coaches who could be trained and certified.

Training programs differ in their graduation requirements. Some only require class attendance, while others require trainees to pass tests to receive certification. The most rigorous training programs require that trainees pass both a written and a competency-based test before granting certification.

Common requirements to participate in peer specialist training emphasize that the student has lived experience of receiving mental health treatment and is willing to self-identify as a person in recovery. Many training programs require that students complete a Wellness Recovery Action Plan for themselves. Several programs require a high school diploma

or post-secondary education. The requirements are similar for recovery coach training. The trainee must be in active recovery and willing to disclose his/ her identity as a person in recovery. Particular training programs stipulate that the person must have at least one year of continuous sobriety or abstinence in order to participate.

Peer training centers may not have capacity to offer continuing education for peer specialists/recovery coaches to improve their competence and maintain their certification. Some training centers have affiliations with local colleges that offer relevant training opportunities. Otherwise, peers/coaches receive continuing education through the workplace and professional seminars. The following is a list of ideas generated by the panel to strengthen pre-service and in-service training for peer specialists/recovery coaches:

- ◆ Balance peer support standards with flexibility, keeping core elements while respecting local context
- ◆ Retain “peer-ness” and recovery orientation in all training; avoid developing training that is only clinical in its approach
- ◆ Develop continuing education modules that can be delivered as in-service training and be shared among programs

No national accreditation or certification for peer specialists or recovery coaches currently exists and people in the field disagree about whether such certification would be helpful. Panelists also reflected different opinions about the usefulness of certification. As of 2008, 30 States have developed criteria for a peer specialist role within mental health systems and 13 States have certification goals or requirements for recovery coaches (Harrington, 2011; Kaplan, 2008).

PEER SPECIALIST/RECOVERY COACH CAREERS

One major difference between peers specialists and recovery coaches is that, whereas most recovery coaches volunteer their services, most peer specialists are employed. Note that most peer specialists work part-time hours and do not receive health care benefits as part of their pay package. Most recovery coaches serve in the field as volunteers while also working at a paying job, and some volunteer for a limited time period as a way of strengthening their own recovery. Many recovery coaches do not desire full-time employment or pay for coaching because they have other jobs or professions. Becoming certified, therefore, is not an interest. Instead, these recovery coaches opt to work as a peer to “give back” as a component of their own recovery plan. This trend of peer recovery coaches serving as

volunteers may be changing as more peers are choosing to develop careers as recovery coaches. As more peer recovery coaches seek paid employment there may need to be a track for training and credentialing for them.

Peer specialists/recovery coaches find few promotion opportunities. Some have left the peer role, obtained a professional credential, and begun to work in other roles. This approach is an undesirable option for others. Many peers want to retain their “peer-ness” while advancing to higher levels of responsibility and pay. Although some agencies find a solution to this dilemma by creating positions and training peers who wish to become supervisors and managers, others have not responded. In a recent survey of peer specialists, low pay was the number one reason that people left their jobs (Harrington, 2011).

SUPERVISION

Supervisors need clear guidance about the roles of peer specialists and recovery coaches, as well as training in how to supervise and support peers/coaches and help them with workplace challenges. Many supervisors need training in how to support peer staff in maintaining their own recovery and how to deal with relapse.

While peers may need administrative supervision to help them manage the demands of the workplace (e.g., record keeping, work schedule), they also need supervision from senior, experienced peers/coaches who can teach and reinforce critical competencies and help with problem solving. A peer supervisor can also share experience, strengths, and hope when the job seems overwhelming.

The panel regards regular contact with other peers who are in similar roles as being very important. Peers/coaches report that they use peer support to help them solve problems, receive encouragement, and discuss the daily stresses of their role. Peers within programs might hold a mutual support group, while the telephone or Internet links others. The state of Georgia reaches out monthly by telephone to every peer working in the system to offer support. One way to create a supportive culture for peers is to recruit peers for roles throughout the agency and to “infuse the system and the program with a strong peer workforce.”

Finally, employers may need guidance about how to tailor performance evaluations to reflect the peer specialist/recovery coach role. Agencies need to ensure that performance evaluations are completed in a way that promotes recovery.

THE UNIQUENESS OF PEERS

In response to the question what are the unique contributions made by peers in behavioral health services, one panelist wrote:

“Peers offer a disbelieving, dispirited, and demoralized person the opportunity to witness and come to believe in the possibility and reality of recovery through the cultivation of a trusting and transparent relationship with someone the person can readily identify through the sharing of lived experience.”

Peer uniqueness has three aspects: who peers are, why they are, and what they do. A peer is a person with lived experience who may come from the same socioeconomic background or culture as the person receiving the support/coaching. In a peer-helping service alliance, a peer leader in stable recovery provides supports to a peer who is seeking help in establishing or maintaining his/her recovery (CSAT, 2009). Both parties are helped by the interaction as the recovery of each is strengthened. People experience the power differential unlike relationships with professionals because the peer’s authority comes from his/her experience. The peer’s experience of being a service recipient and/or having navigated his/her own course through recovery is a crucial part of the relationship. Because transforming their own negative experiences often motivates peers, issues of shame and guilt in both people in the relationship are neutralized.

Peers execute many functions, some of which are offered by others in the behavioral health system, but peers contribute something unique. Peers share their lived experiences and are willing to exchange stories, so long as it benefits the other person. Peers offer hope through role modeling. They are living proof that recovery is possible. Peers may teach relevant and meaningful skills, and tend to focus on life management skills rather than illness management skills. Peers are non-clinical in their relationships and likely to be eclectic in their approach to support.

Theme Four:

STATE MODELS OF PEER SUPPORT/ RECOVERY COACHING

Presentations focused on the different State models of developing peer workforces in the mental health and substance use disorder fields. Panelists spoke about the potential benefits that would come from open dialogues between mental health and addiction authorities because each system may have something to offer the other. Dialogues would allow the systems to share their experiences and strengths around pro-

gram development, evaluation, financing, and policy. Because each State has different resources, open dialogues may allow these systems to share resources and knowledge.

Panelists discussed financing peer support and recovery coaching services. There was consensus on the range of financing possibilities and that no one funding stream fits the needs of all States. Each State must develop a strategy to tailor the funding to meet its specific needs and structure. SAMHSA’s Partners for Recovery has developed a resource, Financing Recovery Support Services, which reviews and analyzes funding options.

Panelists discussed the many ways that States could be supported to develop a peer specialist/recovery coach workforce. Different funding streams may support different peer roles. To fund peer navigator roles, for instance, States have successfully secured funding through managed care organizations and Medicaid. As health care reform progresses, the field should be involved with defining these new reimbursable roles.

States are using a variety of funding streams for peer workforce development, including Medicaid, RCSP, the Substance Abuse Prevention and Treatment Block Grant, the Access to Recovery grant program, State, county, and local funding, and other sources such as Temporary Assistance for Needy Families, drug court funds, and private funding. There was discussion of an upcoming Policy Academy that will be conducted as part of BRSS TACS, coupled with discussion about how States that have developed peer support and recovery coaching services could mentor States that are not as far along in the process.

Panelists noted the importance of measurement and accountability to strengthen peer support/recovery coaching services. There was consensus that program evaluation should be routine, and a recommendation to conduct cost/benefit analyses. Most agreed that reductions in hospital use, decreases in criminal involvement, and increases in employment rates are important outcomes. There is no consensus around which outcomes truly capture the recovery process nor is there consensus about which outcomes should be measured. Quality of life, subjective well being, and community involvement have been proposed as critical measures, although these are less likely to demonstrate cost reductions to the system.

The panel discussed upcoming changes in health reform, including the integration of behavioral health and primary care and its resulting implications. There was considerable discussion about potential roles for peers such as health care

navigators and wellness coaches in primary health care settings. Peer support is thought to complement and enhance primary care services by providing social and emotional support and practice assistance to help people achieve health goals. Peer support can help a person adopt health-promoting behaviors that are needed to manage health conditions. Peers can also enhance primary health care through outreach and engaging high priority groups such as people with chronic health conditions.

DIVERGENT PERSPECTIVES

Throughout the discussions, the panelists identified various points of divergence in opinions. Despite these differences, panelists reached consensus that multiple perspectives need to be considered when developing peer programs. The points of discussion were as follows:

Differences in Implementation between Mental Health & Addiction Systems

One issue that highlighted the differences between the mental health and addiction systems was the payment of peer specialists/recovery coaches. For the most part, peer specialists are paid wages for their services with the majority of recovery coaches providing services as volunteers. A contributing factor to this difference is that in the addiction field, stand-alone agencies without financial support from other larger funding streams are more the norm. This leads to differences in settings, pathways, diverse communities, and more fragile areas of sustainability.

Approach to Relapses

Relapse is associated with mental health conditions and substance use conditions. Both may be marked by periods of remission and struggle. People in recovery from either condition may experience relapse, and being in recovery means that the person learns from the experience and adjusts his/her services and supports to minimize the risk of another relapse.

There was some disagreement among the panel about how to define a person in recovery from addiction. Several panelists asserted strong opinions that a person in recovery from addiction should have a least one year of sobriety or abstinence to become a recovery coach. Most recovery community organizations have personnel policies that address how to deal with relapse and support continued employment instead of job loss. Other panelists had a less definitive definition of recovery, including the principle that “people are in recovery when they say they are in recovery,” and a more nuanced reaction to the employment status of a person who has had a relapse. Many cautioned

that the Americans with Disabilities Act protects people from being asked questions about their length of sobriety and other questions about their recovery.

Recovery Centers & Peer Specialists/Recovery Coaches

Is it better to develop recovery centers that hire peers/coaches to provide recovery support services or to employ peers/coaches in traditional programs throughout the system? Most panelists agreed that both approaches have merit, while recognizing that many States lack resources to expand in both directions simultaneously.

Recovery centers are popular in areas with large populations and are credited with engaging people who might be reluctant to engage in traditional treatment services. In less populated areas, mental health and addiction services are less concentrated and rural areas may not be able to support a recovery center. In these areas, a cadre of recovery coaches and peer specialists may be able to travel to meet the support needs of people working toward recovery. Hiring peers/coaches can help the process of engagement with people outside of a program or within traditional services. However, there are examples of successful recovery centers in rural areas and the benefit of recovery centers in a community, large or small, is that they bring the face of recovery to the community and work to mobilize the recovery community.

Standardizing Training & Interventions Versus Adapting to Local Contexts

There is strong interest in standardizing peer specialist/recovery coach training. Standardizing training would help to ensure that every peer specialist/recovery coach learns the essential knowledge and skills needed to perform their job. Standardizing would allow for better research and evaluation, so peers can continually strengthen the interventions they deliver. Conversely, training and interventions may need to be flexible so that they can be adapted to the local context or modified to meet individual needs. Such flexibility is a critical element in an intervention’s design and delivery.

“Peer-ness” versus Professionalism

The peer-to-peer relationship is described as being mutually empowering (Mead, 2003). The shared experiences of loss and shame, addiction/mental disorders, and the recovery journey strengthen the connection between peers. The relationship provides a degree of normalizing to this shared experience. Indeed, peers are “living proof” that recovery is possible and peers may inspire program staff and participants.

Peer recovery support services can fill a need long recognized by treatment providers: the need for services that support recovery after a person leaves treatment and returns to their communities. Peers hold promise as being a vital link between clinical treatment systems and the larger community in which people seeking to achieve and sustain recovery live.

At the same time, within mental health and addiction programs, clinical services are more widely accepted and quantified. They are deemed essential and reimbursed at a much higher rate. Those who have professional credentials inevitably earn a higher salary than those who do not. Some peers report feeling hesitant to contribute in meetings because the professionals in the program speak with more authority. In this environment, peers/coaches begin to feel pressure to be more “clinical,” and many begin to move away from their peer roots and philosophy.

While retaining their “peer-ness,” peers are being asked to become certified and maintain credentials with continuing education. Many peer leaders in both fields advocate for certified peer specialist/recovery coach roles, and most peers/coaches embrace training opportunities. Many talk about peer support/recovery coaching as professions. This tension point reflects an awareness of the need to retain the roots of peer support/recovery coaching while developing the role’s scope and significance.

These various points of divergence and convergence create both challenges and opportunities to State behavioral health authorities as they work to implement peer models. Although they must not necessarily be fully resolved in order to move forward, these tensions must be acknowledged and addressed in the process of implementation.

Future Directions and Recommendations

At the conclusion of the meeting’s final breakout session, the small groups were asked to suggest concrete approaches for addressing major issues identified in the previous discussions. The panel developed suggestions for policy, practice, resource development, research, and workforce development. These recommendations provide guidance to SAMHSA and BRSS TACS in terms of how to advance the work of supporting States to promote peer specialists/recovery coaches.

1. Develop clear guidelines and best practice recommendations for peer recovery support services in behavioral health programs

It would be helpful to develop “how-to” manuals for implementing peer support/recovery coaching in behavioral health programs, providing guidance while allowing for flexibility to meet the needs of diverse programs and populations. The manuals could provide programs with the information they need to recruit, hire, and support peers/coaches. These manuals will provide details about relevant legal issues, and assist human resource departments in developing universal human resource policies.

In order to develop these manuals, the following steps will need to be taken:

- ◆ Collect information about successes experienced by the behavioral health programs that provide peer support and recovery coaching
- ◆ Review laws, policies, and practices that serve as barriers to employing a diverse workforce, especially peers with criminal histories
- ◆ Review human resource practices and policies to identify those that can be universally applied to the behavioral health workforce
- ◆ Promote strategies that are effective in recruiting, hiring, and integrating a diverse peer specialist/recovery coach workforce
- ◆ Summarize successful practices in recruiting, hiring, training, supervising, and evaluating peers/coaches
- ◆ Describe career ladders for peers/coaches
- ◆ Involve peers in all aspects of the development of these manuals to ensure that peer perspectives are included
- ◆ One possibility would be for SAMHSA to produce a series of Recovery Protocols similar to its series of Treatment Improvement Protocols.

2. Create resources that assist States and authorities to develop, monitor, and finance peer support/recovery coaching services

Develop “how-to” manuals for States and authorities about all aspects of developing, financing, and evaluating peer support/recovery coaching programs. In addition to written materials, the panel recommends creating opportunities for States and authorities to talk to one another about the strategies they use to implement peer support/recovery coaching.

The following actions are recommended:

- ◆ Encourage the Center for Medicaid Services (CMS) to expand funding options for peer support specialists/recovery coaching and to update the State Medicaid Directors’ letter

- ◆ Encourage CMS to review and possibly revise the criteria for “medical necessity” to provide clear justification for reimbursement of peer support/recovery coaching services
- ◆ Involve the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and the National Association of State Mental Health Program Directors (NASMHPD) in a crosswalk of funding options
- ◆ Identify funding strategies beyond Medicaid
- ◆ Develop technical assistance materials that discuss the advantages and disadvantages of different funding options
- ◆ Involve NASADAD and NASMHPD in gathering information about State/authorities’ experiences with developing peer specialist/recovery coaching services
- ◆ Recognize State leaders, both formal and informal, who have championed peer support/recovery coaching services in their States
- ◆ Foster mentoring relationships between State leaders who have not developed peer support/recovery coaching with leaders from States that have significant experience

3. Encourage further research to establish the evidence base of peer support/recovery coaching

The panel agreed that there is a strong need for ongoing research and evaluation to establish the evidence base of peer support/recovery coaching. Research is needed to understand and define the core elements of peer support/recovery coaching, and behavioral health stakeholders need to reach consensus about which outcomes of peer support/recovery coaching are the most important.

To achieve this recommendation, the following steps will need to be taken:

- ◆ Develop plans for research and program evaluation and describe critical outcomes for peer support/recovery coaching
- ◆ Develop typologies of peer support and the level of evidence for each category
- ◆ Suggest measures that capture important outcomes and standardize them across States and programs
- ◆ Evaluate the cost effectiveness of peer support and recovery coaching in behavioral health services
- ◆ Conduct surveys of peers/coaches to learn more about their work experiences

- ◆ Encourage scholarships that fund research conducted by peers/coaches

4. Strengthen training in peer support/recovery coaching and continue to promote the benefits of certification

The panelists agreed that while there are strong training programs for peer specialists and recovery coaches, some are substandard. There was consensus that certification of peers/coaches is a good thing, especially in light of health reforms that may require peers/coaches to be credentialed in order to be reimbursed for their services.

The following actions are recommended:

- ◆ Develop peer support/recovery coaching training program standards
- ◆ Design competency-based training curricula to meet desired outcomes
- ◆ Focus on experiential learning strategies
- ◆ Review certification standards for peer specialists/recovery coaches
- ◆ Educate stakeholders about the benefits of certification
- ◆ Identify core competencies needed by peers/coaches
- ◆ Ensure that “peer-ness” is at the heart of all training

5. Celebrate and strengthen the bonds between the mental health and addiction fields

Expert Panel participants were impressed by the comfort and ease of each discussion. The dialogue demonstrated the progress toward sharing a common vision and language across mental health and addictions recovery. Recommendations were made to enhance this phenomenon of working together:

- ◆ Create mechanisms for mental health and addiction authorities to dialogue about supporting implementation of peer specialist/recovery coaching services
- ◆ Use clear, widely understood language so that the dialogue between systems can continue unhampered by misunderstanding
- ◆ Speak the language of health and wellness

CONCLUSION

As behavioral health systems and authorities strive to become more recovery-oriented, they will need to support the development and expansion of peer-provided services. Fortunately there are many partnerships and collaborations within and between the mental health and substance use disorder

systems that will facilitate the development of peer-provided services and support. Much of the work that is being done now is spearheaded by coalitions of people in recovery and family members who have joined efforts with providers and federal, State, and local authorities. These partnerships will continue to have far-reaching benefits for people who are struggling with mental health and substance use disorders.

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Appendix 1: Commonly Used Terms

The terms peer specialist and recovery coach are used in many ways and sometimes are used interchangeably.

Conventionally, the term peer specialist refers to a person in recovery providing peer support services within the mental health system. Likewise, recovery coach refers to a person in recovery from addiction providing support and guidance to others within the addiction system. As more programs deliver peer-provided support services, the number of terms used to describe peer roles will increase. For the purpose of this report, the following terms are defined as follows:

RECOVERY: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential (SAMHSA, 2011).

PEER: People who share in common a mutual lived experience. In this way, both peer specialists and recovery coaches are peers. In parts of this document, the term peer is used generically to describe either a person who is a peer specialist or a recovery coach.

PEER SPECIALIST: A person in recovery from a mental illness who has specific knowledge through lived experience and competence to assist another person in recovery from mental illness.

RECOVERY COACH: A person in recovery from a substance use disorder who has specific knowledge through lived experience and competence needed to assist another person in recovery from substance use disorder.

IN RECOVERY: A generic term applied to people living with mental illness and/or substance use disorder that implies that the person is practicing self-care and using other strategies to manage the symptoms of the condition and is developing a life of purpose and meaning.

PERSON IN RECOVERY (FROM A SUBSTANCE USE CONDITION): A person who has achieved a period of abstinence from alcohol and drug use and is developing a life of purpose and meaning.

PERSON IN RECOVERY (FROM MENTAL ILLNESS): A person who has achieved some degree of mastery over distressing symptoms and is developing a life of purpose and meaning.

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Appendix 3: Meeting Agenda



BRINGING RECOVERY SUPPORTS TO SCALE
Technical Assistance Center Strategy (BRSS TACS)

BRINGING RECOVERY SUPPORTS TO SCALE TECHNICAL ASSISTANCE CENTER STRATEGY (BRSS TACS) EXPERT PANEL

Equipping Behavioral Health Systems and Authorities to Promote Peer Specialist/ Peer Recovery Coaching Services

March 20 – 21, 2012
SAMHSA Central Office Building
1 Choke Cherry Road
Seneca Conference Room
Rockville, Maryland

AGENDA

Objectives

1. Understand the current practices, implementation strategies, and contexts for peer specialists/peer recovery coaches.
2. Identify innovative workforce development activities and summarize workforce development needs to implement peer specialist/peer recovery coaching services.
3. Develop specific recommendations for Behavioral Health Systems and Authorities as they seek to support and implement peer specialists/peer recovery coaches across a diverse range of settings.

March 20, 2012—Day One

- 9:00 – 9:20 WELCOME & OPENING REMARKS
Catherine D. Nugent, LCPC, Senior Public Health Analyst, SAMHSA/CMHS (BRSS TACS Project Officer)
Deepa Avula, MPH, Chief, Quality Improvement and Workforce Development Branch, SAMHSA/CSAT (BRSS TACS Project Officer)
- 9:20 – 9:30 INTRODUCTIONS
Cheryl Gagne, ScD, Boston University Center for Psychiatric Rehabilitation (BU)
Jeff Olivet, MA, Center for Social Innovation (C4)
- 9:30 – 9:40 GOALS AND EXPECTATIONS FOR THE PANEL
Cheryl Gagne and Jeff Olivet
- 9:40 – 10:40 PRESENTATION AND DISCUSSION: THE STATE OF THE FIELD: THE CHANGING TIDES OF SUPPORT FOR PEER SPECIALISTS/PEER RECOVERY COACHES
Joe Powell, LCDC, CAS, Association of Persons Affected by Addiction, Recovery Community Support Services Organization
LaVerne Miller, JD, Policy Research Associates, Inc.
Lori Ashcraft, PhD, CPRP, Recovery Opportunity Center / Recovery Innovations
- 10:40 – 10:55 BREAK
- 10:55 – 12:00 BREAKOUT GROUPS – THEME: THE STATE OF THE FIELD
- Group 1 – What's already working? Challenges and successes in implementation.**
- Questions for Discussion:*
- ◆ What current peer specialist/peer recovery coaching initiatives, programs, or services exist Statewide?
 - ◆ What challenges prevent Behavioral Health Systems and Authorities from implementing peer specialist/peer recovery coaching services?
 - ◆ What creative strategies have been employed to overcome these challenges?
- Group 2 – Understanding the evidence for peer specialists/peer recovery coaches: Strengths, limitations, and new directions.**
- Questions for Discussion:*
- ◆ What is the current state of the research on peer specialists/peer recovery coaches?
 - ◆ What are the emerging practices and what is the level of evidence for their effectiveness?
 - ◆ What are the gaps in the current research?
 - ◆ What are your recommendations for new directions in research on peer specialists/peer recovery coaches?

Group 3 – Understanding and exploring new contexts.

Questions for Discussion:

- ◆ What new contexts and/or service settings are implementing peer recovery coaching?
- ◆ What strategies do they employ for implementation?
- ◆ Are they distinct or consistent with traditional settings peer specialist/peer recovery coaching services?
- ◆ What is the impact of these new contexts?
- ◆ How are states and programs funding/supporting these new efforts?

12:00 – 12:30 REPORT OUT AND DISCUSS

12:30 – 1:30 LUNCH

Participants are encouraged to bring their own lunch or take advantage of the SAMHSA café.

Understanding the Research (1:00 - 1:30)

Larry Davidson, PhD, Yale School of Medicine

Matthew Chinman, PhD, RAND Corporation

1:30 – 1:40 NEXT STEPS FOR AFTERNOON SESSION

Cheryl Gagne and Jeff Olivet

1:40 – 2:45 PRESENTATION AND DISCUSSION: DIMENSIONS OF THE WORKFORCE

Cheryle Pacapelli, Connecticut Community for Addiction Recovery

Lyn Legere, MS, CPRP, CPS, The Transformation Center

2:45 – 3:00 BREAK

3:00 – 4:00 BREAKOUT GROUPS – THEME: ENSURING A QUALIFIED WORKFORCE

Group 1 – What are the challenges and the needs of the peer specialist/peer recovery coach workforce?

Questions for Discussion:

- ◆ Who currently comprises the peer specialist/peer recovery coach workforce?
- ◆ What are the major challenges that face this workforce, including recruitment, retention, training, and supervision?
- ◆ What are the knowledge and skills gaps of the current workforce?
- ◆ What is the state of certification and accreditation for peer specialists/recovery coaches?
- ◆ What about in new health, criminal justice, or alternate settings?

Group 2 – Understanding current activities and resources that support workforce development.

Questions for Discussion:

- ◆ What tools and strategies are programs using to support workforce development—recruitment, retention, training, and supervision?
- ◆ Specifically, what resources currently exist (toolkits, training curricula, online learning tools, etc.) to support this workforce?
- ◆ What can Behavioral Health Systems and Authorities do to support workforce development activities?



4:00 – 4:50 REPORT OUT AND DISCUSS

4:50 – 5:00 WRAP-UP AND ADJOURN

March 21, 2012 – Day 2

9:00 – 9:30 WELCOME, REVIEW, AND GOALS
Cheryl Gagne and Jeff Olivet

9:30 – 10:15 PRESENTATION AND DISCUSSION: STATE, TERRITORY, AND TRIBAL MODELS
Cassandra Price, Department of Behavioral Health and Developmental Disabilities, Division of Addictive Diseases, Georgia DHS
Joyce Allen, MSW, Bureau of Prevention Treatment and Recovery, Division of Mental Health and Substance Abuse Services, Wisconsin DHHS

10:15 – 11:15 BREAKOUT GROUPS –THEME: HOW CAN WE BEST EQUIP BEHAVIORAL HEALTH SYSTEMS AND AUTHORITIES?

Group 1 – Recommendations for States, Territories, and Tribes to expand peer specialists/peer recovery coaching in traditional settings.

Questions for Discussion:

- ◆ What Behavioral Health Systems and Authorities have effectively expanded peer specialist/peer recovery coaching services?
- ◆ What can be learned from their experience?
- ◆ What advice do you have for Behavioral Health Systems and Authorities as they seek to expand promote peer specialists/peer recovery coaching?

Group 2 – Recommendations for Behavioral Health Systems and Authorities to expand peer specialist/peer recovery coaching services in new settings: Primary Health Care, Criminal Justice Systems, and others.

Questions for Discussion:

- ◆ What States, Territories, and Tribes have expanded peer specialist/peer recovery coaching services into new settings?
- ◆ What can be learned from their experience?
- ◆ What advice do you have for Behavioral Health Systems and Authorities as they seek to expand promote peer specialists/peer recovery coaching in health care, criminal justice, and other settings?



Group 3 – Understanding the structural supports Behavioral Health Systems and Authorities need to advance peer driven services.

Questions for Discussion:

- ◆ What are the financing mechanisms currently in place?
- ◆ What are the emerging financing mechanisms?
- ◆ How can stakeholders in Behavioral Health Authorities build buy-in across their States, Territories, and Tribes?

11:15 – 11:45	REPORT OUT AND DISCUSS
11:45 – 12:45	LARGE GROUP DISCUSSION: NEXT STEPS Cheryl Gagne and Jeff Olivet
12:45	WRAP-UP AND ADJOURN

