discussions have evolved from discussions of barriers and challenges to conversations on readiness (we can do this, let's partner on this).

- **Mr. Obisakan** stressed that work continue towards being more inclusive. He noted a colleague in the Native American community that told him "I'll take you more seriously when you start including us in decisions that will impact my community."
- **Ms. Heffernan** shared that her word yesterday was "pure anxiety" but found that the participants agreed on more things than they disagreed on. There was a lot of discussion about data, but she noted that those in recovery have never been asked to provide data. She also noted how much addressing poverty should supersede all other recovery needs.
- **Ms. Clark** shared that it was helpful to learn more about SAMHSA and what other states are doing to build this "dreamworld" for recovery.

> *Poverty is a major factor. If you ask people in recovery what services they need, many will say they need a place to live…being reflective and accessing emotions is a privilege that many in poverty don't have.*
>
> Ms. Hefferman

Recovery Services in Various Settings

In this panel, speakers from different recovery settings (e.g., RCO, collegiate recovery c/high school programs, harm reduction) shared their perspectives on what they have been doing and the challenges that they have faced.

AJ French

Ms. French is the Chief Executive Officer of Gift of Voice. In collaboration with three universities, Gift of Voice provides training to recovery support and peers specialists. They also offer a recovery support center serving individuals who have mental health issues and have been involved in the criminal justice system. Sessions are both one-on-one as well as group programs and they provide support on financial well-being as well as Wellness Recovery Action Plan (WRAP) support. Because they don't get government funding, they are able to include all groups. They also partner with local organizations which provide material needs (e.g., meals, etc.).

Mike Durchslag

Mr. Durchslag is the Executive Director of Minnesota Transitions Charter School, -P.E.A.S.E. Academy which is the longest-standing recovery high school. He is also a board member with the Association of Recovery Schools which he acknowledged gave him a more macro perspective of the recovery school movement and afforded him more of voice with policymakers.

He would like to see peer support for youth expanded and include "fun" components into recovery services. He started the first Alternative Peer Groups (APGs) in Minnesota for those students that do not attend a recovery-based school.

He also stressed the importance of scholastic recovery in addition to behavioral health support. And he would like to see more connections between the APGs, recovery schools and RCOs.

Tim Saubers

Mr. Saubers currently serves as the Program Coordinator for Workforce Development with SAMHSA's Peer Recovery Center of Excellence which is based out of the University of Texas at Austin. He is also the Board Vice President for the National Association of Peer Supporters. Regarding the Center of Excellence, he noted that there are three other core areas in addition to workforce: integration of peers in nontraditional settings; RCOs; and evidence-based practices. The Center plans to add a fifth core area focused on DEI issues.

The issues that Mr. Saubers works on related to workforce include payment/benefits, certification sustainability and scalability.

Brandon George

Mr. George is based in Indiana and his focus has been on building an infrastructure for peers and RCOs. He noted that other systems (e.g., hospitals community health centers) have an infrastructure but there isn't one for recovery. In Indiana, the state has been a positive ally and there have been efforts to build a system which incorporates housing, community services, and safe spaces. There are currently 20 RCOs and they have been able to provide tailored services for specific subpopulations (e.g., Native Americans).

Mr. George acknowledged that the work is hard and challenging. One of their current focuses have been on how to keep services going after SAMHSA funding ends (e.g., sustainability).

Ahmed Hosni

Mr. Hosni has two roles at Ohio State University. He oversees the alcohol and drug initiatives with the university's Student Life Student Wellness Center and is also the Director of Recovery for the Higher Education Center for Alcohol and Drug Misuse Prevention and Recovery (HECAOD) which serves as a resource for colleges and universities across the nation. He also co-chairs the Association of Recovery in Higher Education and is a board member of the Association of Recovery Schools.

> *When you are in addiction, you lose your dreams. When you are in recovery, they aren't just automatically restored. We need to instill opportunity and hope.*
>
> Mr. Hosni

Mr. Hosni shared details about his lived experience, which included having parents living with mental illness; being in foster care; and being involved in the criminal justice system. He noted that education is a great equalizer as well as an instrumental part of recovery. In his personal journey, he went to Texas Tech University's Center for Collegiate Recovery Communities which overlooked his poor GPA and "were willing to invest" in him. This was a pivotal point in his life and career.

Pam Werner

Ms. Werner is Manager of Recovery Services and Supports for the State of Michigan. She noted that the state has over 2,500 certified mental health peers and 1,800 recovery coaches. They also have nearly 700 veteran peers and 120 peers that are also certified health workers.

One area that Michigan is engaging in is working with peers who are involved in the criminal-justice system. The trainings begin while the individual is in prison and corrections leadership has been quite supportive of the initiative.

Discussion

As the moderator, Mr. Murphy provided some guided questions as well as solicited additional questions from participants.

Regarding recovery support services, what is working well in your local area?

- A peer respite after 15 years of advocacy.
- Also, an increase in peer respites including one specific for veterans.
- More recovery housing, though still not enough.
- Department of Corrections' receptivity to peer training and programs.
- A learning community among RCOs (e.g., shared learning on board management, HR, strategic planning, and grant writing.)
- A greater focus on self-care.
- The addition of peers for parents, youth and individuals with intellectual disabilities and other developmental disabilities.
- More RCOs and not just clustered in urban settings.
- Empowerment of the recovery community – "loud and proud."
- Connections across recovery schools and APGs such as joint proms to create a sense of community.
- Some work on getting recovery support in community colleges.
- Funding provided by the Governor provides more flexibility and new ways of "doing business.
- Opening of a peer-run warmline.
- A recovery housing program that is committed to not calling law enforcement unless the individual specifically requests it.
- Alternatives to Suicide efforts specific to the Lesbian Gay Bisexual Transgender Questioning Intersex+ community.
- A peer fellowship program focused on individuals with multiple intersectional non-dominant identities.
- Expansion of peers in a variety of non-traditional settings and more diversity.
- Partnerships with religious institutions that provide material support and sometimes long-term emotional support.
- Relationships with county government even beyond social services (e.g., housing).

What are the challenges to providing recovery support services in your area? How are you and your organizations navigating these challenges in your area?

- The need to pull more people in the room from differing perspectives and experiences.
- Prevention organizations have payment options other than Medicaid. Why not the same for recovery? Why are we being pushed into a medical model?

> *We need to stop shooting arrows at one another. If we can't agree, then we can't advocate effectively.*
>
> Mr. George

- There should be more collegiate recovery opportunities in trade schools and community colleges.
- Individuals in this room have made recovery their vocation (e.g., helping others). However, there are many others who wish to pursue different careers and educational opportunities will help them do that.
- Peer voices are still missing. Marginalized or tokenized voices are present where policy decisions are being made. We should talk more about relationships as this is part of wellness.
- Treatment providers feel threatened about shared power and sharing funding so they may refuse to support and seek out RCOs that are successful.
- Funding concerns. In addition to sustainability, there is differences across mental health and SUD peer reimbursements.

> *We had a legislative committee that was making policy that would infringe on mental health rights. Because there was no lived expertise represented, it was hard to convince them of our concerns.*
>
> Ms. French (paraphrase)

Audience Questions

The following are questions/comments from audience participants:

- **RCO Financing –** Stephanie Frank shared that in Illinois they provide expense-based coverage of services rather than fee-for-service. This is to help with sustainability. However, she noted that smaller organizations may not be able to provide benefits. Mr. George noted that there is not parity in Medicaid payment and that fixing that might also be useful in providing RCO funds.
- **Recovery and Medical Model –** Ms. Frank added that Illinois is resisting pressure to incorporate RCOs into a medical model (e.g., having to have a clinical person employed).
- **Peer Placements –** Ms. Werner noted that peer placements are "everywhere." This includes libraries, clubhouses and wherever there are individuals in need.
- **Philanthropy Ecosystem –** Ms. Harper noted that the national philanthropy community is small, so it is challenging to identify those sources of funding.
- **Opinions of Faith-based Services –** Some participants identified value in faith-based services and in addition "spirituality" is listed as one of the eight dimensions of wellness. Some participants noted that secular individuals or those individuals harmed by institutionalized religion are consequently made to feel unwelcome or as an "other." It is important to create space that allows people to speak openly out about these negative experiences. It was noted that scholastic recovery services often avoid this focus by design.

> *It is a mistake to medicalize peer services.*
>
> Ms. White

Breakout Session

Participants then met in breakout sessions focused on Peer Services and Wellness. They were asked to discuss the following:

- What is going well in your local community, region, nationally?
- Where do we (the mental health and SUD recovery supports field) need to focus to make positive progress?

- What do you wish the end goal to look like?
- What innovative ideas can we dream up for future local, regional, and/or national impact?

Following are the report outs from each of the groups.

Zoom 1

Where to focus on to make positive progress?

- There are challenges and benefits of Medicaid. Reimbursement should include non-direct engagement (team meetings, notes, etc.).
- Training for peer specialists needs to be robust.
- Address the root causes of peer drift:
    - There is less attrition in peer respites probably due to not having to do a lot of administrative reporting.
    - Clinical staff need to be trained about peer specialists, so they are leveraged appropriately. Wisconsin has a training already developed.
    - Address documentation and training,
    - Be realistic with peer workloads and establish boundaries so that they have a life outside of their peer identity.
    - Create spaces that are safe for peers and a culture that is transparent and builds trust.

What are the top three areas that need attention?

- Providing pay equity.
- Having peers in leadership roles.
- Develop a toolkit for supervising peer specialists.

Zoom 2

Where to focus on to make positive progress?

- Integration with primary services.
- Look at wellness differently - include other programs on nutrition and smoking cessation.
- Health fairs and Hepatitis screenings.

> *Smoking cessation and nutrition are particular wellness programs needed for people in recovery.*
>
> Breakout (paraphrase)

What do you wish the end goal to look like?

- Expand the use of peers and offer for community health worker certification to improve job opportunities/wages.
- Incorporate all the eight dimensions of recovery.
- Focus on physical health.
- Have resources (perhaps from SAMHSA) to help with more detailed financial understanding for individuals (beyond just credit reports).
- Provide more flexibility with time and work structure.
- Improve system navigation and provide it statewide.
- Address confidentiality which protects but also allows for information sharing across systems.
- Increase payment and ensure equity (across States and between mental health and SUD services).

> *We want individuals to have the right resources for when they need it. Like bank ATMs where an individual can get access to their money anywhere.*
>
> Breakout Participant (paraphrase)

Illinois and Wisconsin

What is going well?

- State funding for RCOs has increased. (Illinois)
- There is harm reduction and culture/community building activities (e.g., growing honey, gardens, etc.). (Illinois)
- Many RCOs including collaborative RCOs. (Illinois)
- State mental health and SUD divisions are working collaboratively together. This has resulted in more funds for mental health recovery services. (Illinois)
- There are more credentialed peers. (Wisconsin)

Where to focus on to make positive progress?

- Allay anxiety about building capacity. (Illinois)
- Need to focus more on overall system and why there is attrition. (Wisconsin)

> *The focus on my wellness rather than my illness was a turning point in my recovery. That vision was never offered to me before.*
>
> Nanette Larson

- How to support sustainable structures. (Illinois)
- Peer attrition.
- Culture is too focused on illness, disorder, and deficit management rather than wellness.

What do you wish the end goal to look like?

- Provide a collaboration of financial administration to allow RCOs to have this expertise but also be able to focus predominately on the work they do best.
- Offer seed money to new RCOs which has no government regulations tied to it.
- Culture should be on wellness (positively) rather than the current approach of focusing on someone as being sick.
- Inclusive with no us versus them mindset.
- Greater diversity of peer specializations.

> *Apply radical empathy eliminating "othering" people. This includes not just individuals but also State and clinical staff who may not understand our perspective.*
>
> Illinois/Wisconsin group (paraphrase)

<u>Michigan and Ohio</u>

What is going well?

- More acceptance of the integration of peers and wellness.
- Better reimbursement and sharing of funding.
- Increased services that promote wellness and help rebuild recovery capital.
- A workforce curriculum to train employers about peers and the advantages they offer.

What do you wish the end goal to look like?

- Robust research about RCOs and peers to demonstrate their strengths and any barriers to their success. Should include cost-benefit analysis.
- A connected national network for advocacy and research-based storytelling on peer benefits.
- A diversity of funding sources (private and public).
- Recognition of expertise reflected in the pay.
- Recovery-friendly workplaces and wellness programs.
- Person-centered approaches.
- Innovation research and published articles.
- Address stigma as well as fear (e.g., some professions are at risk of losing their license if they share they have a behavioral health concern).
- "Infiltrate" settings where peers can be beneficial.

> *Recovery is complex. Innovation rather than cookie cutter approaches is needed. These illnesses pivot so recovery services should be allowed to do so also.*
>
> Michigan/Ohio group (paraphrase)

Minnesota

What is going well?

- Strong collaboration and support across treatment entities and RCOs.
- Expanded peer support for youth.
- Building a community and offering social activities. (St. Louis)
- Trained peers in recovery schools.
- Good collaboration with faith communities.
- Increase in recovery coaches and navigators.
- Partnerships built from "top to bottom."
- Standards set and more internships to build more confidence in the peer workforce.
- Mental health and family peers are part of Certified Community Behavioral Health Clinics (CCBHCs).
- Innovative police assistance programs connected with pre-treatment housing.
- Partnerships with and training of law enforcement and emergency management systems (EMS).

Where to focus to make positive progress?

- Educate legislators and family who may not know the difference between treatment and recovery and the types of services (e.g., RCOs). As a result, decisionmakers may fund treatment and feel that also addresses recovery.

What do you wish the end goal to look like?

- Develop standards for RCOs.
- Focus on long-term recovery and building of recovery capital.
- Provide a payment structure that is equitable across the service spectrum (e.g., RCOs, treatment, etc.).

Prioritization Activity

Mr. Murphy asked participants to share the top three actions that they would like to see happen in the future. The responses were:

- Examine better funding options.
- Make sure that all settings where peers work know and respect recovery values.
- Foster partnerships with clinical communities rather than being a separate system or co-opting peers into the medical model.
- Expand recovery beyond peers and RCOs.
- Develop a broad data strategy that extends beyond peers.
- Provide SUD and mental health recovery services, though integration may not always be the best approach.
- Maintain integrity of services. While it is good to expand peers, if everyone is considered a peer, it will erode the value and integrity.

- More inclusion of historically marginalized communities who have been left out because of systematic racism, the requirement of abstinence, mass incarceration and the reliance on faith-based approaches.
- Philanthropy likes to fund proof of concept projects, so this can be a resource for funding innovation.
- Focus on whole-body wellness which is home, health, and purpose. If these aren't being met for the individual, the recovery is not doing what it is supposed to.
- How might we gather information about peer attrition without being intrusive?
- Provide more clarity on peer support/services - is the terminology serving us well? The field needs to stay true to the values and authenticity. There is a toolkit that has peer support values translated into scope of work. This could be used to provide more clarity.
- There is an effort to professionalize peers to garner respect. It is important that authenticity is not lost or compromised in the process.
- Continue to embrace tension in these discussions. They are uncomfortable but it will be how we make progress.
- Address implicit bias since peers have different paths to recovery. For example, with younger individuals, the term recovery might not resonate. This conversely creates a dissonance for peers as they need to compartmentalize their experience to meet a person where they are. But it is the peer's beliefs/lived expertise which makes them valuable.
- Professionalism through certification is predicted on assimilating with traditional clinical attitudes within predominantly white-centric workplaces. Professionalism instead should be a clear understanding of what we do; a commitment to excellence; and a pursuit of visionary work.
- It is difficult to tie lived experience and our value within a capitalist economy framework. Peers are job roles while lived expertise is an identity.

> *Lived experience should have respect regardless of the individual's professional background.*
>
> Kristen Harper group (paraphrase)

> *Lived expertise is something I have. Peer support is a job skill set.*
>
> Nze Okoronta

Wrap up and Next Steps

Ms. Harper thanks participants and noted that a report will be generated. She will share it with participants for review. Ms. Harper will also share contact information (e.g., emails) of participants.

About the Realizing Recovery Series

To advance recovery across the nation, the Office of Recovery (OR) forges partnerships to support all people, families, and communities impacted by mental health and/or substance use conditions to pursue recovery, build resilience, and achieve wellness. With this goal in mind, the OR initiated a series of (in-person, virtual, or hybrid) dialogue, technical expert panel, and summit-style convenings, beginning in February of 2023 with SAMHSA's Technical Expert Panel on Peer Support Certification.

The themes across these convenings, which range from strengthening the peer workforce to advancing recovery across tribal and justice-involved communities, each align with an objective, strategy, or priority within SAMHSA's National Recovery Agenda. All convenings, both past and present, reinforce efforts to forge new partnerships while strengthening old. Further, each convening and associated report serves not only as a foundation and guiding light for the Office of Recovery moving into 2024, and beyond; but also provides SAMHSA, the OR, and our federal, state, local, tribal, and territorial partners with the information that is needed to advance recovery across the nation.

To access materials and publications related to recovery—including other reports within the Realizing Recovery Series, please visit https://www.samhsa.gov/find-help/reco

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation.

Appendix A: Participant List

*Participated virtually

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Appendix B: Region V Peer-Related Activities

State	Activities
Illinois	• Increased funding for employees and retention payments/grants for providers. • Academic Center of Excellence partnership / funded a 'behavioral health care education workforce center' to assist with crisis workforce shortage. • Certified Recovery Support Specialist Program – course work, internship, and behavioral health workforce placement in partnership with universities. • Career pathways for Peers in Medicaid create equality for peer professionals related to pay/supervision capabilities.
Indiana	• Current efforts to standardize and professionalize the peer state certification. • Intense focus on recovery data collection. • Recovery Research project underway currently. • Legislation mandating peers on mobile crisis teams.
Michigan	• Parent Support Partners imbedded into children's behavioral health system. • Increased peer support specialists in forensic/clinical settings. • They intend to incorporate incentives to address the social determinants of health. • Currently 13 CMHCs that are CCBHCs, and they were told that if they are either an existing • CCBHC or a CMHC that would like to expand into being a CCBHC that they could apply. • MI's community mental health organizations are obligated to provide crisis intervention regardless of if an individual identifies as being severely mentally ill or in the moderate or mild category.
Minnesota	• TTI Grant 2023 - Building Crisis Services that Serve Under-Resourced Minority Communities. • They plan to standardize certification of peers – connected with Texas in 2023. • There is some hesitation from providers to incorporate peers into their crisis service systems due to challenges with workforce recruitment in general.
Ohio	• Loan repayment and tuition reimbursement for treatment sector with goals to expand into recovery sector. • Ohio investing in statewide Peer recovery organization model to support state infrastructure. • State-wide recovery summit coming up – lots of national representation. • Recent collaboration with state of Indiana/ • Specialized peer track to include Latin-x and LGBTQ+ /

	• Initiatives to hire peer specialists who are deaf or hard of hearing.