PRO-A PRELIMINARY REPORT TO DDAP ON STRATEGIC PEER WORKFORCE DEVELOPMENT

December 31, 2019

This preliminary report is being distributed to the field for review and comment. Feedback will be incorporated into a final report to be submitted to DDAP in the Spring of 2020

PRO-A Report to DDAP on Strategic Peer Workforce Development
- Executive Summary -

In July of 2019, the Pennsylvania Recovery Organizations – Alliance (PRO-A) was tasked by the Pennsylvania Department of Drug and Alcohol Programs (DDAP) to develop a Strategic Plan that evaluates the current CRS peer professional workforce. The process included examining the barriers and workforce opportunities in Pennsylvania for developing an effective peer professional workforce to serve our state's needs for the future. PRO-A has worked to examine these needs and to make recommendations for future enhancements of the peer workforce and related resources within the substance use peer recovery support service (SUPRSS) system serving Pennsylvania.

This process was an important opportunity to examine key trends to engage and grow an effective workforce. It includes a focus on ethical skill development to navigate the complex situations surrounding individual engagement into the system of care, and through to long term recovery. It also examined needs to support care through supervision and mentorship as well as the impact of stigma on our workforce. There is an emphasis on expanding peer professional training to historically marginalized communities. It is recognized that the recovery community has largely been the backbone of our substance use disorder (SUD) workforce historically. This report is largely conceptual and we invite the opportunity to further operationalize overarching strategic suggestions in order to fully support the objectives of our Pennsylvania Department of Drug and Alcohol Programs. Our review was a comprehensive approach integrating input from:

- A range of stakeholders and recovering community members in Pennsylvania
- Survey data from SCAs, Treatment Programs, RCOs and CRSs
- Review of existing and current literature on workforce development and peer services.

Key Findings of this Report:

Based on this review, themes are summarized to represent concerns and ideas from across the spectrum. It includes recommendations from these findings to guide steps to move forward with expanding recovery to more Pennsylvanians. This report reviews key factors such as the need:

- To engage a robust peer professional workforce capable of supporting the growing need for peer-based services, and our larger SUD service system.
- To strengthen high quality ethical service delivery to maintain sustained effectiveness, and
- To stabilize the system by management of mentor and supervision processes to provide a consistent structure for those in the existing workforce.

It is important to understand that the core CRS training was intended to be a "basic training." As our care needs have developed, we are recognizing the need to prepare people for specialized care settings that have evolved in recent years. Training and supervision are core elements in workforce retention and development. It is important to focus resources on these elements if we are to properly develop our workforce to serve our communities. It is also recognized that this will need to be an ongoing process as the utilization of SUD peer professionals is anticipated to continue to evolve to meet the needs of are larger SUD service system.

Key Recommendations:

The existing literature and survey data suggest key steps to address each of these areas such as:

- Engagement:
    - Compensation rates, career paths, perception of our workforce
    - Retention and development of peer professional workers is critical to our future service system workforce capacity.
- Quality Improvement:
    - Training, education, evaluation, use of efficacy data
- Stabilize structure
    - Supervision, mentoring, core competencies
    - Robust supervision and mentoring resources are critical to sustain and expand our workforce capacity.
    - Peers in the system are facing challenges due to high stress situations like emergency department engagement at times without specialized training or supervision to promote effective and ethical navigation through these situations.

We envision a SUD peer professional workforce that is properly prepared, engaged and retained to serve our care system over the long term. It is understood that it takes years of focus and training to develop mastery of the skills and knowledgebases needed to provide effective care. This strategic report is intended to set the stage for developing out SUD peer professional workforce with this in mind. These steps can be accomplished as a part of DDAP's 3-year plan to strengthen and grow the service system.

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PRO-A Report to DDAP on Strategic Workforce Development - Overview

1. **People in recovery from addiction have historically been the bedrock of the SUD systems workforce. By focusing on our recovering workforce, Pennsylvania can revitalize our substance use care system and prepare for future care needs.**

   Our entire SUD care system and its infrastructure are underfunded and overburdened, this has resulted in low pay, fragmented care, and systemic workforce development deficits across the entire workforce. These dynamics significantly impact peer recovery services, a critical element in an effective treatment and recovery support care system. As persons in recovery are the bedrock of our SUD System workforce, development focused on this level is the key to ensuring we have a workforce that can rise to meet the needs of the next generation.

   A. **Strengthening Our Care System through Supervision:** Develop and implement peer recovery supervision and mentoring while incorporating it into the care model to strengthen practice, sustain ethical conduct and retain our workforce over the long term.

      a. Incorporating supervision into our peer service models is critical for the retention and the development of our peer workforce. This can be achieved through funding supervision, training and education of peer supervisors to support CRSs and CFRSs operating across Pennsylvania.
      b. Mentoring can support cohesive care as isolated workers have access to support while improving role delineation and skill development. Mentoring can be particularly important for peer providers operating in isolated settings without other peer workers to learn from and can be organized statewide to serve all peer providers as an available resource for CRSs and CFRSs.
      c. The establishment of a statewide peer mentoring and peer supervision resource network can support innovative practices, understand low compensation challenges and other barriers while emphasizing ethical care processes to expand skill development to augment Pennsylvania's long-term workforce needs.

   B. **Skill building for peer professionals:** Strengthen peer workforce through training / education / career ladders for peer engagement for CRS, CFRSs and peer supervisors to strengthen workforce cohesion and system wide capacity in respect to treatment and recovery care needs.

      a. Expand peer supervision training with a focus on inclusion of CRSs becoming supervisors in order to develop a reservoir of supervisors grounded in SUD peer professional work.
      b. Ensure that all peer service funding mechanisms include supervision requirements in order to ensure we are engaging all SUD peer workers in effective workforce strategies.
      c. Establish a statewide SUD peer service statewide conference to bring together SUD peer professionals and strengthen cohesion across the SUD peer service system while developing connections between SUD peer professionals operating in diverse communities across the state.

   C. **Strengthen Networking Capacity for Peer Professionals:** Develop our recovery resource network to strengthen career pathway development, training and education pathways. This will

ensure that our current CRS and CFRS workforce is ready to be the next generation of care system leaders on the community level in ways that support ethical care for persons seeking help with a substance use disorder.

a. Support a statewide peer professional resource clearinghouse to assist in the establishment of Recovery Community Centers that address recovery support needs and increase the visibility and acceptance of people in recovery grounded in the community.
b. Support the development of SUD peer professional training focused on recruitment and retention of the peer workforce and ultimately the larger SUD workforce as persons with direct, lived experience of a SUD have historically been the backbone of our entire SUD service system workforce.
c. Engage the recovery community to develop a deeper understanding of career pathway opportunities to a career in SUD care and work with the recovery community and other stakeholders to decrease barriers such as low pay, historic criminal justice involvement and other barriers moving forward.

2. **Deep, collaborative inclusion of people in recovery in system design, development and service delivery would increase meaningful service system improvements. This will revitalize our workforce and establish the infrastructure needed to meet the needs of the next generation of Pennsylvanians seeking help with an addictive disorder to ensure partnered commitment to our workforce needs.**

The recovery community is the cornerstone of our SUD system workforce, and effective solutions must include people in recovery in system development, facilitation, and evaluation across our care system in collaborative, cross-pollinating ways.

A. **Expand Innovative Practices for Peer Professionals:** Engage the statewide recovery network to collaboratively augment local, regional and statewide recovery support efforts that strengthen innovative practices and incorporate them into a sustainable long-term care workforce model. Expand practice opportunities that serves rural, suburban and urban Pennsylvania communities while improving public perception about our workforce.

a. Training should be developed specifically for persons already certified as CRSs in order to provide an opportunity to explore real world ethical conduct dynamics out in the field. This training would focus on facilitated discussions that would highlight the role and function of supervision, review relevant ethical codes and review our ethical responsibilities to our larger service system and ensuring that ethical conduct concerns are addressed and reported when such reports are indicated.
b. Task the recovery network with developing a media campaign focused on SUD peer services in collaboration across the recovery community focused on the role and function of CRSs and CFRSs within the workforce to normalize recovery and show that the work is a rewarding, lifelong career path.
c. Have the network engage with local and regional and statewide organizations from across the SCA, RCO and treatment systems in order to develop deeper insights into

innovative practice and share those models in cross collaborative fashion across care systems through training, education and technical assistance.

B. **Strengthen Recovery Community Engagement in our Care Systems:** Incorporate the recovery community across SUD care system development, facilitation, and evaluation processes in order to deepen commitment, insight and feedback loops across our care system.

   a. Continue to engage the authentic peer community in peer service system development in order to retain the essence of SUD peer services in the future and ensure that there is strong collaborative connection with the recovery community served across Pennsylvania by the SUD care system.
   b. Recognize that we must prepare people for specialized care settings beyond the core CRS "basic training" as our care needs have evolved. Bring service systems together and support the development of training by the authentic recovery community to address our systems evolving needs in communities served across PA.
   c. Set up a feedback loop that engages with CRSs and CFRSs to identify evolving needs and barriers across Pennsylvania in order to improve workforce training and retention of our SUD peer workforce to ensure a continuous quality improvement feedback system.

C. **Expand Effective Recovery Oriented Care:** Establish social indicators of recovery in close partnership with the recovery community to measure recovery as part of a long-term care system and support a workforce prepared to meet our SUD recovery care needs.

   a. There is growing recognition that we must develop our care systems to support long term recovery. This is fundamental for strengthening effective care models, improve outcomes and save resources. Establishing social indicators of recovery across our care system like stable housing, employment and disengagement with our legal system can help focus both the care and the supporting workforce towards our ultimate goal, long term recovery.
   b. Recovery measures like the BARC-10 can help focus SUD peer professionals to provide effective services that supports long term recovery. CRSs, CFRSs and the programs that employ them should be trained in and encouraged to use validated recovery-oriented tools to measure and support the development of recovery capital.
   c. Resources should be focused on data collection from recovery community organizations and treatment organizations deploying peer professionals. Data on long term recovery can be collected with software programs such as the Recovery Data Platform developed by Faces & Voices of Recovery (Faces & Voices). The collection of uniform data supports effective care over the long term as there will be a deeper understanding of the efficacy of the care provided. The data can be used to focus workforce training, education and supervision initiatives in ways that closely support the objectives of our larger SUD care system.

3. **The opioid epidemic has led to recognition that addiction is commonplace. We have the opportunity to improve public perception about recovery and destigmatize our workforce. Addressing ethical conduct issues collaboratively with our community is critically important to improving public perception about us.**

Stigma against people with substance use disorders, people in recovery and the professionals who serve in our substance use treatment and recovery support systems underpins systemic barriers to entrance into and retention in our SUD treatment and recovery support workforce. We must eliminate it.

A. **Assure Ethical Referral and Care:** Collaborate with the recovery community to educate the public about patient brokering and other ethical conduct issues to eliminate them and protect our own vulnerable community members.

   a. CRSs and recovery community organizations could be utilized to expand public awareness about patient brokering and eliminate brokering that prey on our own vulnerable community members.
   b. Focusing our recovery communities on providing care to high ethical standards through statewide training and education is crucial for eliminating unethical conduct by CRSs and CFRSs operating out in the field.
   c. Collaboration at the recovery community level focused on ethical conduct concerns ensures deep engagement and the development of resources to support needs at the local level and develop insight into local needs and strengthen our overall workforce capacity.

B. **Expand Peer Training to Marginalized Communities:** Develop education and training that supports all of our communities, including those within historically marginalized groups. Use our developing peer workforce network to engage with our medical and human service systems to improve understanding, training and education about addiction and recovery to serve all communities in PA, including those historically underserved.

   a. Expansion of CRS training and SUPRSS services to non-English speaking communities is a critical component of a comprehensive SUD peer workforce strategic plan.
   b. The development of CRS training models incorporated within historically black colleges and universities (HBCU) and community colleges in marginalized communities is important for a comprehensive SUD peer workforce strategic plan.
   c. Conduct educational campaigns in collaboration with the recovery community focused on our human service and medical care systems emphasizing that treatment and recovery support services work and include people in long term recovery to help reduce negative perceptions about addiction and recovery.
   d. Collaborate with the recovery community to bring recovering professionals and overdose survivors in recovery into medical and human service systems in order to improve perceptions about recovery across these institutions.

C. **Educate Peer Professionals on Recovery Housing Standards:** Develop education on Recovery Housing for our peer workforce and the public to ensure ethical practices around recovery housing referral from our SUD peer and treatment workforce.

   a. There is a unique opportunity to train our peer workforce in our new recovery housing standards – this would be system wide training on what these standards do and how

this housing fits into our larger SUD care model. It is critically important to ensuring that the new standards are effectively implemented.

b. Ethical care within recovery housing is important. Training our peer workforce about ethical care within these houses will be critically important to ensuring that people are served properly in recovery housing operating across Pennsylvania.
c. Recovery housing in other areas of the nation have been particularly vulnerable to patient brokering activities – training our peer workforce in ethical referral practices is one of the best measures we can take to protect persons being served within our recovery housing system.

PRO-A Strategic Plan Report to DDAP
The CRS workforce – Barriers and Opportunities for the future

Overview / History of the CRS Credential and workforce development

PRO-A was one of the first Recovery Community Organizations in the United States, and from our inception we have been focused on expanding opportunities for persons in recovery, including within the service system workforce. In 2008, as the statewide recovery community organization (RCO), PRO-A came together with other recovery community organizations in Pennsylvania and met with the Pennsylvania Certification Board (PCB) to establish a credential for persons in recovery to provide peer recovery support services to persons seeking help for a SUD. The collaborating organizations included PRO-A, PRO-ACT, Message Carriers and the RASE Project. This peer credential was envisioned to be part of a system of care provided through authentic, recovery community organizations (RCO) operating within the community and providing recovery support services before, during and after formal treatment for an SUD. This work was fully supported by the Pennsylvania Department of Health Bureau of Drug and Alcohol Programs, the Pennsylvania Department of Public Welfare, PA and the Governor's Office as there was a related process to develop a White Paper around Recovery Oriented Systems of Care (ROSC). It was envisioned that this would occur and be funded in a manner that supported the need for the services and included stakeholder recovery community organizations in the design, implementation, provision and evaluation of the care conducted (PA ROSC White Paper link here).

The credential was adopted by the Pennsylvania Certification Board (PCB) in 2008. At that time the intent by the RCOs groups was to limit the credential to recovering persons, however the decision was made to not require recovery initially as part of the credentialing process. That was changed in 2017, with persons applying for the credential to go through an attestation process with a requirement of 18 months of recovery – the process in which these policies were revised occurred in a collaborative manner with RCO stakeholder groups. It was at that time the Certified Family Recovery Specialist (CFRS) credential was developed, also collaboratively between the PCB and PRO-A to include the family lived recovery perspective.

At the inception of the CRS Credential, Pennsylvania was one of the first states in the nation to develop a credential for SUD peer services, with the majority of other states adopting such a credential over the ensuing decade. The stakeholder groups from the SUD recovery community have recognized that while there are many similarities with mental health peer services, there are differences between the needs of persons with SUDs and that a stand-alone credential serves our communities best. The CRS training

consists of 54 hours of training across the core competency areas of approved education across several domains including Recovery Management, Education and Advocacy, Professional Ethics and Responsibility, Confidentiality, and other training relevant to addiction and recovery.

It was recognized since the early years of the CRS credential and the development of recovery support services that the "basic training" for a CRS was just that - basic training. Implementation and funding of peer services since the inception of the CRS has extended beyond authentic, recovery community organization and adopted by SUD treatment providers, county governments and other institutions, such as hospitals and human service agencies. Initially, the basic training for the credential was provided by a handful of RCOs who had collaborated on the development of the credential and were invested in the development of services designed by and for persons in recovery from a SUD for persons seeking help with a SUD. Since that time, a variety of organizations and institutions who may or may not be aware of the relationship between the CRS credential and recovery focused care provided by the authentic recovery community through community based RCOs have developed and are providing training for this credential across the state.

The basic CRS training has evolved over the years through periodic reviews by the PCB in order to ensure that the training has remained consistent with the needs of our SUD services system. The PCB examines and revises the core domains via a key informant process conducted through interviews with CRSs and CRS supervisors conducting the work. While it was initially envisioned that SUD peer services would be funded and provided statewide in a similar manner as the Mental Health peer services conducted by Certified Peer Specialist, that were developed and funded statewide over a decade ago, SUD peer services have never been funded in a comprehensive manner. This has resulted in patchwork funding, significant differences in the types of SUD peer recovery services funded and a paucity of authentic community-based recovery community organizations engaged in the provision of these vital services (White, 2010). This is primarily as a result of very limited resources focused on this element of our substance use care system. There remains a disparate access to peer services between mental health peer services and SUD peer services and significant differences between the infrastructure of care that has been able to develop on the mental health side that has been unable to occur to the same degree on the SUD side over the same decade.

Expansion of training and peer workforce competencies has also been limited, as is the case with funding and care disparities. This is true also in respect to peer supervision, both here in Pennsylvania and nationally. PRO-A recognized several years ago that development of competencies around supervision would be critically important for workforce retention and the development of a high-quality peer workforce. We began examining what was occurring nationally and discussing these needs with the PCB in late 2016, dialoging with organizations around country and researching what was available in the literature in respect to SUD peer supervision competencies. We recognized that few states had developed anything around this important need. PRO-A saw that the need existed and in collaboration with the PCB, PRO-A assembled a group of content experts from around Pennsylvania who convened in our offices to develop core competencies for SUD peer supervision. These competencies were finalized in June 2017 and posted by the PCB. PRO-A also developed training based on these competencies which has been made available statewide. Funding limitations and a lack of focus on this very important element of peer workforce development has resulted in low integration of peer supervision competencies across our systems.

As a significant amount of the literature indicates, the SUD care system nationally is in a workforce crisis (ATTC, Sept 2017). There is some evidence, including what we found in Pennsylvania when we conducted our workforce surveys, a significant portion of workers who have been retained in the work over the long term are people in recovery who got into the field through certification and then pursued formal college education. This may be an important consideration in respect to retaining and developing our peer workforce. Retention and development of SUD peer workers is also important as the provision of career pathways into different roles within our care system may be vitally important to the health and vitality of our larger SUD care system. A concept model for apprenticeships for CRSs in SUD system workforce that supports a career ladder to counselor roles was completed in 2018 and is attached as an addendum to this report as a consideration to address SUD counselor shortages.

Another area of development over the last decade has been recovery housing. Recovery housing has become increasingly more available in communities across Pennsylvania. Recovery housing has become more important for person in recovery as it is an opportunity to develop supports in a stable and safe environment. Even as this housing has become more prevalent, there has been a wide variation in the quality of recovery housing available. Far too often, persons in recovery are taken advantage of by operators who are not adhering to high standards. Pennsylvania is in the process of adopting standards for recovery house operation in order to ensure safe, ethically operated recovery housing as the standard of care across Pennsylvania. Many houses have initiated CRS training for persons operating the houses to obtain the CRS Credential. This often comes out of a desire to get more engaged in the workforce. A strategic opportunity for development exists to train CRSs to understand the requirements of the new recovery house standards and to support operation under these new standards to ensure that the people that they are working with our served to high standards and are able to access recovery housing that is safe and ethically operated.

Preparing our workforce for conducting recovery support services for the coming decades means focusing on the long-term needs of our community. Understanding social indicators of recovery and integrating measures of recovery into SUPRSS while educating our CRS and CFRS workforce about long term recovery and its measures would provide the foundation for effective care moving forward. Training and education on measures of recovery, such as the Brief Addiction Recovery Capital (BARC-10) that are simple measures of recovery capital would strengthen practice and aid in the development of long-term recovery measures to support care across the continuum. The BARC 10 is a validated tool that is simple to use that has predictive validity of sustained remission (Vilsaint, Et al 2017). There are data gathering tools developed by and for recovery community organizations that are being used across the country to gather data about the effectiveness of recovery support services. Integrating this data gathering tool, the Recovery Data Platform RDP for recovery community organizations statewide can help us gather data from programs across the state, strengthen understanding of the efficacy of services being provided and support training and supervision processes to focus the peer workforce on effective care (Faces & Voices).

The opioid epidemic has taxed our care system and as a result of the significant issues around these needs, public dollars have flowed into our state care system. These dollars have been largely opioid focused, with an emphasis on warm handoffs for overdoses, physician training and housing first as some examples of how resources have been allocated. These initiatives have been tremendously helpful and have saved lives. It is critically important to understand that addiction is often associated

with multiple drugs as part of the substance use disorder. Whole person care is vital to recovery. Concurrently there has been an increase in service roles for persons holding the CRS credential as well as the addition of the CFRS credential, developed collaboratively between the PCB and PRO-A. This has occurred in the context of our service system being in a crisis – which it is. We are losing thousands of people a year to overdose, which is one element of the larger addiction "epidemic."

This opportunity to provide a strategic plan to expand focus on peer workforce development was initiated by DDAP. This focus on peer workforce strategic planning offers an opportunity to develop more methodical processes focused on our peer workforce in collaboration with the recovery community. It will be critically important to focus resources on training and supporting these peer professionals and developing our larger care system to be flexible and well prepared to handle the complex needs of the coming decades of 21st century SUD care system.

Discussion points from this section:

- The development of SUD peer services originated with recovery community organizations and was part of the larger "new recovery movement" to develop community based, recovery-oriented services by and for people in recovery. It will be important to continue to engage the authentic peer community to retain the essence of SUD peer services in the future.
- The core CRS training was intended to be a "basic training" as our care needs have developed, we are recognizing the need to prepare people for specialized care settings.
- Expansion of recovery specialists training has originated out of advocacy efforts of recovery community organizations who early on recognized that we will need additional structure to take peer services to the next level.
- Recovery measures like the BARC-10 can help focus SUD peer workers to provide effective services that support long term recovery. CRSs and CFRSs and the programs that employ them should be trained in and encouraged to use tools like this.
- There is a unique opportunity to train our peer workforce in our new recovery housing standards – system wide training on what these standards do and how this housing fits into our care model is critically important to ensuring that the standards are effectively implemented.
- Data on long term recovery can be collected with software programs such as the Recovery Data Platform. This can support the collection of uniform data that supports effective care. This data can be used to focus workforce training, education and supervision initiatives.

CRS Survey Results

Overview of CRS survey:

PRO-A conducted a survey of CRS across Pennsylvania in the Fall of 2019. We had 100 respondents to our survey that was focused on barriers and opportunities responses related to workforce challenges for SUD peer recovery specialists. As not every respondent answered every question, percentages are reflective of the total sample, not those who responded to each question. The age breakdown of respondents was 13 or 13.54% who were between the ages of 25-34, 24 or 25% were between the ages of 35-44, 32 or 33.33% were between the ages of 45-54, 23 or 23.96% were between the ages of 55-64 and 4 or 4.17% were over 65 years of age. In respect to gender, 39 or 40.21% identified themselves as male, 56 or 57.73% identified themselves as female, 1 or 1.03% preferred to not respond and 1 or 1.03% self-identified as "U", which may refer to unsure. In respect to race, 69 or

71.88% identified as white or Caucasian, 19 or 19.79% identified as black or African American, 4 or 4.17% identified as Hispanic or Latino and 4 or 4.17% wrote in Biracial (white/black), More than one identified as non-binary and two or more races respectively.

Distribution of survey respondents:
Respondents came from 33 different counties or roughly half of the state, including each region and from urban, suburban and rural counties. 79 or 96.34% indicated that they were in recovery, and 3 or 3.66% indicated that they were not in recovery. 10 or 12.35% indicated that they were in recovery less than three years, 21 or 25.93% indicated that they were in recovery between three and five years, 24 or 29.63% indicated that they were in recovery between six and ten years, 9 or 11.11% of the respondents indicated that they were in recovery between eleven and fifteen years, 6 or 7.41% respondents indicated that they were in recovery between sixteen and twenty years, and 11 or 13.58% indicated that they have twenty years of recovery or greater. It is important to note that over 80% indicated that they were in recovery for three or more years.

Educational background of CRS Survey respondents:
In respect to education, 22 or 24.44% had a GED or a high school diploma, 25 or 27.78% had attended some college, 20 or 22.22% have an Associate's degree, 15 or 16.67% hold a Bachelor's Degree, 7 or 7.78% hold a Master's Degree, and 1 or 1.11% held a PhD. We asked about the length of time that respondents were certified, and 44 or 46.32% hold their CRS for less than one year, 33 or 34.74% hold their CRS for 1 to 2 years, 16 or 16.84% hold their CRS for 3 to 5 years, and 2 or 2.11% hold their CRS credential for 6 to 10 years. It is important to note that nearly half of the respondents in this survey held their credential for more than one year.

Employment of CRS Survey respondents:
With respect to employment, 62 or 63.95% currently report being employed in work other than as a CRS and 34 or 35.05% indicated that there were currently employed as a CRS. Comments on this question included that people were employed as certified peer specialist, certified peer forensic specialist, certified peer support supervisor, WRAP facilitator, in direct care, at a Treatment Facility, Treatment Counselor at a Jail, Supervisor for a recovery house, managing nonprofit Christian Recovery Houses, Security/ tech on a crisis unit, working in a women's transitional program, work supporting part time in a MAT clinics and SCA Administrator a examples of the wide variety of alternative employment of persons holding the CRS credential.

Use of CRS credential:
44 or 57.89% of the respondents indicated that they are using their CRS credential in a manner that augments their employment and / or serves their community. 32 or 42.11% indicated that they were not using their CRS credential in any capacity currently. Sample comments include using the CRS training daily with peers served, and helping people find treatment and provide them resources, multiple respondents said that they couldn't afford to work as a CRS as the pay was below a living wage. Several respondents indicated that they volunteer within treatment and / or recovery community organizations. Several noted that they are working in a treatment facility serving the community to help people in recovery on their journey back into society, other examples of alternative employment include helping Juvenile Probation and CYS Cases, employed with an SCA, volunteering with a prison/recovery ministry, working in a woman's shelter among other response examples. It is important to note that nearly 4 in 10 identified that they were not using their credential for anything.

This suggests a reserve of people who were invested enough to get the credential but whom for whatever reason are not engaged in the work.

Employment barriers experienced by CRSs:
When asked about employment barriers, 29 or 54.72% indicated that there is a lack of employment opportunities in their area, 4 or 7.55% went through the training and decided to not pursue work as a CRS, 4 or 7.55% were unable to take work offered, 11 or 20.75% indicated that compensation was too low to accept a position, 2 or 3.77% indicated that they were employed but it did not work out. 20 or 37.74% applied for work but was not accepted for employment. Respondents were asked to provide comment, and responses included that they were not permitted to work in our treatment facilities, hospitals and jails because of a felony arrest record. A common theme was that employment was limited and there was a lack of employment within range to realistically find and sustain employment. Lack of a driver's license was a commonly identified barrier. Several indicated that they were offered

54% of respondents indicated that there is a lack of opportunities in their area
20% indicated that the salary was too low to accept a position

positions within the SUD care system that offered higher pay, suggesting that the training may be seen as beneficial beyond SUPRSS work within our larger SUD service system.

One of the most common barriers identified for employment as a CRS, was a lack of a driver's license. Compensation was also a commonly identified barrier, with one respondent indicating that entry level Walmart workers make more than CRSs and that there are protests against workers' pay at Walmart. Several noted that they don't want to be struggling financially the rest of their lives because they chose this type of work. Multiple comments reflected a lack of employment opportunities for CRS. We asked about the current CRS workforce and Substance Use recovery service needs, and it was noted barriers are across a wide range, willingness to obtain help, transportation, lack of substantial employment opportunities, lack of transportation for clients/people. A lack of treatment beds, people knowing they can recover but afraid to seek help, limited resources and an incomplete continuum of care. It was noted that some systems require that clients test positive for drugs on the spot to get admitted to care as well as long wait times for admission and systemic stigma about addiction and people in recovery.

Discussion points from this section:

- Persons obtaining the CRS credential often hold positions outside of SUPRSS work and find the credential beneficial to supporting objectives. Understanding the credential as a base for our larger SUD workforce needs is an important consideration moving forward with SUD peer workforce strategies.
- The majority of respondents were in longer term, stable recovery – this may suggest that they are persons in second careers and non-traditional learners. This needs to be considered in respect to workforce recruitment and retention strategies as these workers may access training and have different reasons to engage in peer services as a career option.
- 75% of the respondents identified either lack of employment opportunities or low pay as significant barriers for people who want to do this work that need to be eliminated moving forward.

- A criminal justice history and / or lack of driver's license can be a significant barrier to employment – criminal records associated with addiction are commonplace as drug use is largely illegal.
- Stigma against persons in recovery were cited as barriers for person in recovery obtaining or retaining employment in the substance use care system. We must continue to engage the recovery community and make recovery highly visible as part of the larger strategy to reduce stigma and expanding our workforce.

SCA and SUD Treatment Survey

Overview of SCA & SUD Treatment Provider Survey on CRSs:
The survey had a total of 59 responses, 36 or 61.02% reported as SCAs and 23 or 38.98% identified as treatment providers. Not all respondents answered all questions which impacted calculated percentages. Responses came in from all across the state, with a geographical representation of Pennsylvania including urban, suburban and rural counties. As the survey was distributed to SCAs who in some instances forwarded them on to treatment providers, we did receive multiple surveys from the same counties, with the highest number coming from Delaware County with 7 responses and Armstrong at 6 responses. As several counties operate as joiner counties, we noted that several of the 59 county responses included response from SCAs serving joiner counties.

Full time CRSs in the Workforce:
49 or 85.96% of the 57 respondents who answered this question indicated that they had full time CRSs in their workforce, 8 or 14.04% indicated that they did not. There were 159 full time CRSs reported by the respondents. The average number of full-time CRSs reported by respondents employed is 5, the median full time employed CRSs by respondents was 6.5 and the mode of the respondents was 1 full time employed CRS. It is worth noting that having only one CRS working in a system was identified as being isolative. Workers in these settings may have reduced access to peer supervision and an increased need for support and mentorship.

Part time CRSs in the Workforce:
30 or 54.5% of the 55 respondents who answered this question indicated that they had part time CRSs in their workforce, 25 or 45.5% indicated that they did not have any part time CRSs in their workforce. There were 38 part time CRSs reported by the respondents, with the average number of part time reported by respondents being 3.6, the median part time employed CRSs by respondents was 3.5 and the mode of the respondents was 1 part time employed CRS. It is worth noting that having only one CRS working in a system was identified in our interview process as being isolative. As with the full-time response, this suggest that workers in these settings may have reduced access to peer supervision and an increased need for support and mentorship.

CRSs operating in different care settings:
Reported care settings for CRSs employed included 58 responses, with 30 or 51.72% of the CRSs are employed by licensed treatment providers, 8 or 13.79% are employed in hospital or medical settings and 9 or 15.52% are employed by Recovery Community Organizations. 20 respondents commented in the category of other indicating that the CRSs were employed directly by the SCA or were conducting in other settings including working in and around the criminal justice system, children and youth or within case management units, as CPS, and within employment agencies as examples.

Supervision of CRSs:
While peer professional supervision competencies have been established in PA, training in the field for SUD peer supervisors has been minimal. 56 survey respondents identified some form of supervision for CRSs employed in their work place. 42 or 75% indicated that some form of supervision occurred

> *Supervision was often CRS participation in clinical team meetings, rather than specialized supervision on the needs of the peer.*

regularly, 6 or 10.71% indicated that there was not regular supervision, and 8 or 14.29% of the respondents provided a more detailed response, indicating the question was not applicable to their setting, that CRS are employed by agencies that provide supervision, that they did not employee any at this time, that the CRS or team supervisor conducts individual sessions or that supervision was part of the clinical team and clinical meetings as examples of how supervision was managed. Interviews with key informants revealed a wide variation in what supervision looked like. Some supervisor was very informal, other supervision was being conducted by clinical care teams with little insight into the role and functions of SUD peer professionals. The interview process also suggested a relationship between supervision and peer professional retention and development.

Workforce Retention of CRSs:
SCAs and treatment providers responding to this survey, identified workplace retention considerations. Of the 56 respondents, 37 or 66.07% indicated that they are not experiencing retention issues with CRSs employed in the workforce, while 18 or 32.14% indicated that they had retention issues. 10 respondents provided comments on the question, indicating that the question was not applicable, that agencies they work with do not report turnover in CRS positions, that contracted providers see a lot of turnover because they are not salaried positions, that CRSs work on fee for service contracts and do not have regular hours, that in one instance the SCA has employed two CRS's that are salaried and it works much better than the responding treatment provider, that part time or on call positions are next to impossible to fill or keep filled, that low salary forces CRSs to look elsewhere or work a second job, that the respondent has had CRS's leave employment due to personal issues, and eventually, there have been reports of relapse, that turnover seemed related to the pay not being so great, that it is very hard to find full-time CRS due to the low wages, that they experienced high turnover and would be happy to discuss and that there are some issues, but most are because they gain experience and move onto a more professional role.

CRSs employed in capacities other than peer support:
SCAs and treatment providers who participated in the CRS workforce survey noted the frequency of CRSs employed in a capacity other than in a peer support role. Of the 56 respondents to this question, 38 or 67.86% indicated that they had CRSs employed in capacities other than as a CRS, while 17 or 30.36% indicated that did not have CRSs employed capacities other than as a CRS. 14 respondents provided comments on the question. Of the 14 comments, respondents indicated that they did not know or it was not applicable to their setting, one indicated a CRS is working in interventions and family support, one is employed as an assessor; the others also fill in as House Managers in an

inpatient unit, one respondent noted that CRSs are instrumental in decreasing AMAs but at the same time struggle to maintain healthy boundaries with clients who they know from the community.

Several respondents indicated that CRSs are employed by treatment providers in roles like residential tech staff or receptionist. It was noted that CRS support D&A screenings and assessments. They also sit on various committees and subcommittees for housing, re-entry services, and reinvestment projects. CRSs were identified as working with the Veterans Administration on several projects. Respondents noted that CRSs help develop needed services, resources, and programs for the community not just related to Recovery Support Services. CRSs conduct Narcan training in the community and with people coming out of our jails and prisons. Respondents indicated that CRSs offer assistance to local communities to implement Recovery Month activities, one respondent indicated that they have a CRS working in the capacity of a residential house supervisor.

One SCA noted that they have a functional unit, with an inpatient and outpatient treatment provider, and they had one CRSs is a supervisor and another is certified both as a CPS and CRS, and that CRSs are employed as treatment service techs. Within one SCA, 2 CRSs currently make up the Community Engagement Team, which is more a crisis-related role that works intimately with EMS. Survey respondents also noted that CRSs also have assisted clerical with the scanning of client charts due to clerical workforce shortages. One respondent noted that many of our CRSs create community programs for individuals in recovery as well as facilitate and support recovery events within the community. It was stated that CRSs are working in hospitals and connected through crisis to complete screenings and often assist with accessing treatment admissions. SUD Peer professionals support individually identified strengths, assets and skill sets that get utilized accordingly to benefit the agency as a whole. Outreach and community advocacy were reported roles conducted by CRSs, these include partnerships with outside agencies in effort to close gaps in the community. One respondent noted that a CRS with additional education and training had a role in case management functions.

Ethical conduct issues related to CRSs:

The survey included questions about ethical conduct issues specifically with CRSs functioning within the substance use care system. It was noted in review of the data that nearly 100% of the respondents to this question also noted ethical concerns in a question on ethical concerns related to the SUD Professionals who are not CRS certified. This suggests that ethical concerns should not be solely focused on our recovery workforce but beyond it to the non-recovering workforce as well. This also suggests that recovering people in our field are no less ethical than any other type of helping professional, which is important to note as societal stigma still associates addiction and recovery with a lack of morality despite all the evidence to the contrary.

57 respondents answered the question on ethical conduct of CRSs, of those 44 or 77.19% indicated that there were not aware of ethical conduct issues with CRSs functioning in the substance use care

77% were not aware of ethical conduct issues with CRS

system in their areas. 13 or 22.81% indicated that they were aware of ethical conduct issues of CRSs. There was a total of 8 comments to this question. Those comments included that the CRSs on staff

may have a hard time adjusting to privacy and boundary issues. It was noted that this is particularly the case when they know people from the community or their own recovery support pathways.

Respondents noted that there have been a couple of relapses of CRSs and thought that these may be related to boundary issues but did not further explain this potential relationship. A respondent expressed concern that there was a need to focus on maintaining professional balance of work, recovery and home. It was noted that this can be difficult and that maintaining positive mental and emotional health as an employee operating in a high stress environment can be a challenge. One respondent identified that a CRS was not being open to MAT as a positive pathway to recovery. One respondent expressed concern that unclear boundaries of a CRS, such as relationships with some clients of the opposite sex; going to a client's home; providing CRS services while not on duty was a dynamic that they saw.

Discussion points from this section:

- SUPRSS Services are expanding across PA and vary across region and service need.
- CRSs are employed in roles beyond SUD peer services that are beneficial to their communities and expand our overall workforce reservoir.
- Clearer role delineation of CRSs conducting services in PA would be beneficial for the development of SUD peer services and would support ethical care to persons served.
- Incorporating supervision into our SUD peer service models is critical to the efficacy of care and the development of our workforce in ways that support ethical conduct
- Mentoring can improve care as isolated workers have access to support while improving role delineation.

Information from interviews with SCAs, RCOs, Treatment and Peers

Information in the following sections was gathered through interviews and interactions from across stakeholder groups. Formal and informal interviews were set up with several SCA directors, County Human Services Directors, treatment professionals, RCO operators and individual CRSs. Where possible we have added citations referencing similar findings in the available literature to augment and support what survey and data gathered through this review process.

Lack of clear role delineation for SUD peer professionals

CRS professionals conducting Substance Use Peer Recovery Support Services (SUPRSS) have evolved in a patchwork fashion as one respondent noted, “we are building the plane as we are flying it.” Treatment facilities have added on peer workers to fulfill a wide variety of roles, as have counties and insurance companies. Concern about role clarity is not just a state problem, it is being identified on the national level as well (Pantridge, et al, 2016). At times, CRSs can be seen as transportation drivers for programs, to take them back and forth to support meetings, or doing outreach in the community. This can take them far afield from the chain of supervision and at times being placed in environments that are high risk for their own physical safety and result in significant stress. Some CRSs identified being very isolated, working in care systems with little supervision or support. CRS professionals with unclear roles, working in high stress, isolative environments may be at a particularly high risk for burnout (Bassuk Et aL, 2016). This theme was reflected in several of our interviews with key informants.

There are also issues with dual relationships inherent to being a member of the recovery community working in a care system in a peer service capacity (Chapman Et al, 2018). The very nature of the role and function of the CRS providing peer services to members of the community may add to unclear boundaries due to the nature of the work. Issues around this came up in discussions with SCA directors, treatment providers and RCO staff. At times CRSs are presenting in front of courts that they were involved in or working in hospital settings with very complex dynamics. From our discussions with stakeholder groups across Pennsylvania and nationally, the lack of clear role delineation is an overarching concern for the SUD peer professional workforce. We see this as an opportunity to explore and work to define boundaries by the recovery community from within rather than externally to avoid paternalism and loss of the fundamental element of peer services operating within a recovery oriented system of care.

A lack of role delineation can further exacerbate role confusion and result in CRSs being expected to perform tasks for which they have not been properly trained as tasks were added without forethought to training. It may also result in CRSs being underused or not used at all if providers, supervisors, or administrators may be unfamiliar with their training, skills and the role and function of a CRS operating within their systems. CRSs are being hired and utilized in treatment centers, hospitals and by SCAs who have varied perspectives of what a CRS is and what they do and funded in a variety of manners. CRSs should not be conducting duties more commonly associated with counseling or case management. They should not be conducting clinical work, like diagnosing or assessing clients, yet this may not be universally understood across our care continuum. This makes role delineations even more necessary for effective service delivery.

Discussion points from this section:

- Increased role clarity needs to be a focus of a strategic workforce initiative in order to support the efficacy of the work and the development of our SUD peer workforce.
- Peers may operate in work settings with a high likelihood of exposure to stressors and secondary trauma. Supervision is important for the support and development of these workers as there are increased risks of burnout, relapse or leaving the workforce entirely. Supervision must be made routine and readily available.
- Training, education and development of SUD peer supervisors must be included as a required element of peer services, this requires proper funding that "bakes" supervision into funding mechanisms.

SUD Workforce challenges grounded in stigma and negative perceptions about addiction

Through our interview process, it became apparent that negative public perception about people with substance use disorders is pervasive and by extension a significant workforce barrier across the entire SUD care system. It effects how people perceive the field and the professionals who work in it. Stigma associated with SUDs is also greater than those for mental health conditions (Yang, Wong, Grivel, Hasin, 2017) which has policy implications for the entire system of care. Sadly, addiction is still perceived as something that people have decided to do to themselves and therefore, they are less deserving of resources and support. As peer services are conducted by and for people in recovery, the impact of stigma on the recovering workforce is exacerbated in respect to this segment of our workforce as recovery is central to their identity.

Stigma was referenced in many of the state hearings as part of the HR 590 of 2015 process that occurred across Pennsylvania to identify barriers to care within the SUD Service system. Testifiers noted that stigma against SUD and professionals who work in the SUD services system is prevalent and a major barrier to having a more robust workforce. As the final HR 590 report noted, "stigma unnecessarily negatively prevents individuals from seeking help and produces negative opinions and lack of support for those individuals with an SUD or the SUD service system (PA DDAP, 2017)."

Stigma against persons with substance use disorders and recovering persons was also noted in the PRO-A Systems Under Stress Report, a workforce survey completed for DDAP in 2013. It came up as a theme from the 837 SUD professionals who responded to the workforce survey. As one respondent noted in referencing system barriers to effective care, "professional people with good hearts have been systematically disempowered to responsibilities of system improvement and advocacy (PRO-A, 2013)." Stigma is a central factor in low pay, high administrative burdens and negative perception about persons with substance use disorders and by extension the professionals who serve them across Pennsylvania and beyond.

Stigma has been a factor in keeping persons experiencing substance use conditions and their families vulnerable to entities that would prey on them for material or other gain. The explosion of patient brokering, which is a form of human trafficking is related to stigma as families are reluctant to seek help openly. This has also resulted in information about effective programming and the risks of being taken advantage of by a patient broker more likely than it should be. CRSs and CFRSs are at high risk for being used by patient brokers to secure patients or conduct services in an unethical and or illegal manner. It will be important to address patient brokering in ways that include our peer workforce and the general public in order to eventually eliminate patient brokers from preying on our own community.

Through the current survey and interviews process conducted by PRO-A over the summer and fall of 2019, persons working as CRSs identified stigma as a factor in their employment, both internal and external to the programs that they worked in. Interviewees and survey respondents reported that people in recovery were looked down on by non-recovering staff, that some felt like they were discriminated against within the workplace because they had a history of addiction and were even called disparaging names. This dynamic is not limited to Pennsylvania, several national studies link stigma to workforce challenges within the SUD workforce system. One study on burnout associated stigmatizing attitudes about persons with substance use disorders with counselor burnout (Vilardaga, Et al, 2011). The US Department of Health and Human Services identified workforce stigma as a barrier within our SUD workforce. The Road to Recovery Discussion Guide Television and Radio Series identified stigma as a major barrier to developing an effective addiction care workforce (2018).

Workforce development, including the comprehensive training and supervision of our peer workforce, coupled with development of viable career pathway models for persons in recovery to advance into leadership roles are fundamental elements in normalizing recovery in our SUD service system workforce and eliminating stigma.

Reducing stigma associated with our care system is critical to our success in revitalizing our workforce. A parallel exists between the new recovery movement and that of the gay rights movement that started in the late 1960s. Being visible was a central focus of the gay rights movement and was a

central strategy of the gay rights movement, one that the recovery movement has also adopted. It is important to note as there must be an emphasis on visibility and inclusion for successful change to occur in respect to the recovery movement and the acceptance of the recovery workforce as well (Hill & White, 2015). Engaging the recovering workforce more centrally in workforce development is a key element to establishing a viable workforce for the next generation and eliminating negative public perception about the SUD workforce and the communities that it serves.

Discussion points from this section:

- We recommend a media campaign focused on SUD peer services and the role and function of CRSs within the workforce to normalize recovery and show that the work is a rewarding, lifelong career path.
- Collaboration with the recovery community to educate the public about patient brokering and other ethical conduct issues to eliminate them and protect vulnerable populations should be a central element of our SUD peer professional workforce strategy.
- Supporting Recovery Community Organizations (which are run by people with an ADA recognized disability) to increase the visibility and acceptance of people in recovery who work in our SUD workforce can expand peer worker retention and focus needs on ways that are grounded in the needs of the community.
- Conducting educational campaigns focused on our human service and medical care systems emphasizing that treatment and recovery support services work would help reduce negative perceptions about addiction and recovery.
- CRSs and recovery community organizations could be utilized to expand public awareness about patient brokering and eliminate brokering that prey are on vulnerable community members.
- Ethical care within recovery housing is important. Training our peer workforce about ethical care within these houses will be critically important to ensuring that people are served properly in recovery housing operating across Pennsylvania.
- Recovery housing in other areas of the nation have been particularly vulnerable to patient brokering activities – training our peer workforce in ethical referral practices is one of the best measures we can take to protect persons being served within our recovery housing system.

Need for specialized training and soft skill development

We received feedback that there is a need for specialized training for some CRSs operating in more intensive work environments. The deployment of CRSs conducting substance use peer recovery support services was not adopted quickly and it was implemented in patchwork fashion with limited funding. We also heard that some workers may benefit from soft skill development that improve their ability to operate in professional environments. As noted in a prior section, this training was envisioned essentially as a "basic training" for persons to become CRSs, not a comprehensive training for all SUD peer professionals operating in all care settings.

It was noted through our interviews that in recent years there has been a significant expansion of peer engagement in the warm handoff process focused on emergency medical settings for persons with opioid use disorders who have experienced overdoses. "Warm hand offs" came up in the survey and interview process as part of this strategic plan development. Work done in medical settings with overdose survivors is an example of a specialized use of peers in a specific setting. There was some

evidence from our review process that this work is high stress and may benefit from more specialized training, education and support. There is also some sense that supervision is particularly indicated for peer professionals conducting this work as it is being conducted in such emotionally and psychologically intense settings.

There have been efforts to develop supervision competencies in consultation with other RCOs nationally and in collaboration with the Pennsylvania Certification Board. There have also been efforts to develop additional training around topics such as supervision, secondary trauma, wellness, self-care and resiliency. We recognized these elements were needed for having a more viable and effective workforce. Developing additional specialized training in close consultation with CRS conducting specialized peer services our in the field would assist in developing training informed directly by the practice. This would assure that the training is properly aligned with the needs of the community.

As the use of CRSs out in the field is evolving to include their use in warm hand offs for medical conditions associated with addiction beyond overdoses, within human service departments, with children and youth, and for outreach and engagement through harm reduction and other strategies. All of these elements of SUPRSS require knowledge and skill sets beyond the basic training for certification as a recovery specialist. A methodical development of training around specialized needs can support the development of a more effective, engaged peer workforce that is more likely to be retained over the long term.

Likewise, peer supervision is critically important to the development and retention of an effective peer workforce. As noted previously, training around the supervision competencies that were developed in close collaboration between the PCB and PRO-A is an essential element of a peer workforce strategic plan. Additionally, funding and supporting supervision for SUPRSS is essential for retaining and developing the peer workforce. These settings have considerations around secondary trauma that necessitate the use of supervision to support the workers. While these are important considerations, little has been done on a systems level to ensure the development of effective supervision for SUD peer workers in Pennsylvania. Some models reviewed outside of PA require supervision at a minimum threshold and if supervision requirements are not met, the peer worker is not permitted to conduct services out in the field for a period of time. Such measures that are developed in a way that considers real world needs and limitations in our service system are advisable.

Additional training and workforce development should be incorporated to prepare people in recovery as an important as part of our training efforts. While lived experience is the hallmark of a peer worker, not all persons in recovery coming into professional work settings may be properly prepared to work in these various settings. Our survey and interview process reflected concerns about basic workplace preparedness, soft skills and learning about setting specific knowledge. An example of this is the use of medical terminology and medical care system procedures and hierarchy is fundamentally important for CRSs to effectively navigate within these setting.

Discussion points from this section:

- Develop specialized training in collaboration with CRSs in the field in order to strengthen peer workforce capacity
- Expanding peer supervision training with a focus on inclusion of CRSs becoming supervisors in order to develop a reservoir of supervisors grounded in the work.

- Ensuring that all peer service funding mechanisms include supervision requirements.
- Basic job etiquette and soft skills development of specialized service settings is needed in order to improve worker retention in various service settings.

CRS Ethical Conduct Concerns Examined

Throughout the survey and interview process, a significant amount of time was spent on exploring ethical issues related to CRSs. One important point to note is that in our survey process, we asked about ethical conduct issues of CRSs as well as ethical conduct issues related to workers within the care system who were not credentialed as CRSs. This would encompass counselors, case managers and others as defined by the person answering the question. As society may still view substance use disorders a moral issue, it is critically important to note that the rates were comparative to other professionals who are not necessarily in recovery. One interviewee identified that the CRSs she was working with had a better grasp of ethics and boundaries responsibilities than other professional groups she had worked with. Although anecdotal, the data we collected through surveys, interviews and by collecting data would bear out that ethical conduct issues are roughly equal among non-CRS workers as in CRSs workers. The rate of ethical conduct issues of CRSs does not seem that high comparative to other professions in general, although it is important to proactively address emerging themes and patterns.

Having noted similar rates of ethical conduct rates between CRS and non CRS workers in the SUD Service system, it is critically important to understand the kinds of issues that are being identified within the CRS workforce and work to further improve training, support proper supervision and take whatever steps are necessary to ensure persons served are done so in a highly ethical manner that supports quality care and does not place them at risk in any way.

The PCB report noted that since 2009, 2469 CRSs have been credentialed. Of those, 1530 are currently CRS. The report recorded the following:

- 32 Alleged Violations by 30 individuals (roughly 1% of the 2469 CRSs certified over this time);
  - 4 of the Alleged Violations were Dismissed;
  - 6 resulted in Written Cautions
  - 4 resulted in Suspension of Credential
  - 5 resulted in Revocation of Credential
  - 13 resulted in Credentials being made Inactive (Recurrence of Use aka Relapse)

This data indicates a very limited number of violations reported and should temper our read of this. Recurrence of use is characteristic of addiction as it is with other chronic conditions.

38% of CRS have not maintained certification.
This may be a reflection of the ongoing workforce shortage.

- It was noted that 939 of the 2469 (38%) individuals certified in the past 20 years are not currently certified. The number of those training but not keeping their certification active is in line with, or lower than the number in other states. As an example, Georgia historically has about 50% of those trained who remain active. Some of these individuals may have not recertified because of recurrence of use or some other violation never reported to the PCB. Our survey and interview process described throughout this report gives some sense to reasons why some who are trained are not currently certified.
- For the 1530 CRSs still certified, there may be violations never reported to the PCB.
- There were no violations reported that we are aware of until 2015.

Even acknowledging these factors, the number of individuals with reported violations that were not dismissed and did not result in a caution remains less than 2% of the total certified in 10 years is remarkable and might suggest that overall, training and supervision methods are working well.

It is also worth noting that self-reported relapses for all credentials results in the credential being put on inactive status until such time as the individual is back working, being supervised, and documented by their employer that they are able to return to work. For CRSs, they must also have 18 months of continuous recovery again before their credential can become active again since this is a requirement for holding the credential. It was noted that trends identified through the review process are related to relapses and sexual misconduct with service recipients.

This table summarizes the report submitted to PRO-A by PCB. Information shared with PRO-A was aggregate and did not include person identifying information.

Violation Reported	**Year**	**Notes**	**Result**
1. Dual Relationship	2015	Self-Report of potential dual relationship	Case dismissed. No dual relationship.
2. Dual Relationship/ Romantic involvement	2016	Female having romantic relationship with male peer receiving services	Revocation
3. Dual Relationship	2016	Female having dual relationship with male	Revocation
4. Arrest for open Lewdness	2017		Suspension of credential
5. Dual Relationship/ Romantic relationship	2017	Male having romantic relationship with female client	Revocation
6. Breach of Confidentiality	2017	Unfounded	Dismissed
7. Dual Relationship/ Romantic relationship	2017	Female having romantic relationship with male client	Revocation
8. Dual Relationship/ Sexual relationship	2017	Female having romantic relationship with male client	Revocation
9. Posting damaging comments about former employer	2018	Individual posted damaging comments about former employer on social media	Written caution

10. Arrest for assault	2018		Written caution
11. a. Alleged false advertisement of services b. Violation of confidentiality	2018	CRS falsely advertised services and allegedly posted pictures of clients on social media without permission	Dismissed – accusations could not be substantiated
b. Positive urine screen	2018		Suspension
c. Recurrence of use	2018	Employer reported recurrence of use	Status made inactive
d. Alleged defamation	2018	Alleged defamation of other individual in the field	Written caution
e. a. Dual Relationship Sponsorship b. Counseling without qualification c. Posting inappropriate comments on social media	2018	CRS allegedly doing counseling when not qualified to do so, breaching confidentiality, posting inappropriate comments on social media which resulted in a written caution.	Written caution
f. Dual Relationship/ Romantic relationship	2018	Individual had romantic contact with a client	Suspension
g. Dual Relationship/ Romantic relationship	2019		Suspension
h. Recurrence of use Individuals 18-29	2019	12 self-reported recurrence of use	Inactive status until Require 18 months of continuous recovery, Supervised, documented by supervisor that they have been able to return to work.

Here is a breakdown of the types of violations reported, with results of the investigation by PCB and where the violation is addressed in the training and/ or ethical codes provided by the PCB in the Fall of 2019:

Recurrence of substance use (14)

- 1 positive drug screen – resulting in suspension (2018 – 1)
- 1 reported by employer – resulting in inactive status (2018 – 1)
- 12 Self-reported in 2019 – resulting in inactive status (2019 – 1)

For comparative reference, as of 12/1/19 according to the PCB Ethical Violation page located here,

2019 suspensions CRS = 3

CPS = 2
CAADC = 1
CADC = 1

2018 Suspensions
CRS = 2
CPS = 1
CAADC = 1
CAAC = 1

2017 Suspensions
CRS = 2
CADC = 1
CAADC = 1
CCDP = 1

No 2015 Suspensions listed

2016 Suspensions
CADC = 2
CAADC = 2
CRS = 2
CAAC = 1

2014 Suspensions
CADC = 4
CAAP = 1

Discussion points from this section:

While increasing with the expansion of SUPRSS services in recent years, ethical conduct issues are relatively low for CRSs in comparison with other service professionals – focusing on high ethical standards is crucial for keeping such instances low and avoiding unethical conduct by CRSs operating out in the field.

- Training should be developed specifically for persons already certified as CRSs in order to provide an opportunity to explore real world ethical conduct dynamics out in the field. This training would focus on facilitated discussions that would highlight the role and function of supervision, review relevant ethical codes and review our ethical responsibilities to are larger service system and ensuring that ethical conduct concerns are addressed and reported when such reports are indicated.
- Supervision is critical for effective care and keeping ethical conduct instances low as services continue to expand.

Expansion of Peer Training and Services in Marginalized Communities

In Pennsylvania, the training for the CRS credential and the provision of SUD peer services has been developed in a piecemeal fashion, largely based on where opportunities to do so have presented themselves. Training of CRSs and the expansion of peer services in a more methodical manner is necessary moving forward to ensure the availability of quality peer services facilitated by trained peer professionals in all communities. We have an opportunity to expand training and peer services to support communities that are disadvantaged and have not historically received the support that they should receive for training and services.

Bilingual, bicultural CRSs able to serve non-English-speaking communities such as Spanish, Korean or Chinese speaking are few and far between. To the best of our knowledge CRS training in PA is not available in any language other than English. Training non-English speaking or English as a second language individuals in recovery to be CRSs should be a central strategy in supporting services to these communities, as well as a focus on funding care to non-English speaking or English as a second language communities.

As peer service are most ideally provided by persons who have similar life experiences, CRS training and SUPRSS services should be focused on addressing the needs of various commuities. African

American populations are a good example of a community that has been historically underserved by our treatment systems while at the same time over represented within our criminal justice systems. CRS training should be conducted more methodically with marginalized populations and the development of peer services within marginalized communities should be given the highest priority to expand services to these communities.

The model of CRS training in academic institutions such as the model developed in close coordination between PRO-A and Luzerne County Community College could be replicated within Historically Black Colleges and Universities (HBCUs) operating in Pennsylvania, such as Lincoln University. This model would be particularly advantageous as it provides an entranceway into higher education with college credits as the student obtains basic certification and would therefore be more attractive to non-traditional students. The OVR apprenticeship model at the back of this report is also ideally designed for use within communities in which resources for education are at a premium.

Discussion points from this section:

- Expansion of CRS training and SUPRSS services to non-English speaking communities is a critical component of a comprehensive SUD peer workforce strategic plan
- The development of CRS training models incorporated within HBCUs and community colleges in marginalized communities is important for a comprehensive SUD peer workforce strategic plan
- Having a peer workforce that is representative of the communities served is fundamental to developing a workforce that can properly meet the needs of all of our communities.

Summary / moving forward / next steps

PRO-A believes that the development, training and support of the SUD peer professional community is critically important to the long-term development of our overall workforce capacity. While SUPRSS services and the peer professionals who provide them are expanding, they remain one of the greatest underutilized resource we have to support recovery, both nationally and across Pennsylvania. The ideas and recommendations contained in this strategic plan report are intended to be considered for inclusion in the DDAP 3-year plan and we hope that they may be part of shifting our care system towards a long-term, recovery focused model in collaboration with the authentic recovery community.

The identification of needs through surveys, gathered data and interviews framed in this report were completed in the late summer and late fall of 2019. As we were finalizing the preliminary report for distribution and comment from the field in mid-December we learned that the PCB decided to extend the 54-hour CRS training to 75 hours and that a standardized curriculum will be developed by the PCB. We look forward to engaging with the PCB and service providers in this process in a manner that reflects the origins of the training as it was conceptualized and developed by the recovery community and for the recovery community.

We will be posting this preliminary report on our web site at http://pro-a.org/ and will circulate it widely with our members, recovery community organizations, treatment providers, SCAs and BHMCOs across Pennsylvania for comment and feedback through a survey tool. We will incorporate feedback we get into the final version of the strategic peer workforce plan to submit to DDAPs review and approval in April 2020. We look forward to being involved in efforts to engage, expand and strengthen the CRS workforce and improve high quality ethical care across our service system.

Sources

ATTC Network, (September 2017), NATIONAL WORKFORCE REPORT 2017 Strategies for Recruitment, Retention, https://www.drugsandalcohol.ie/28384/1/ATTC_Network_Natl_Report2017.pdf

Bassuk EL, Hanson J, Greene RN, Richard M, Laudet A. (2016). Peer-Delivered Recovery Support Services for Addictions in the United States: A Systematic Review. J Sub Abuse Treat,63:1—9.

Bouchery, E., Dey, J. (2018). SUBSTANCE USE DISORDER WORKFORCE ISSUE BRIEF. US Department of Health and Human Services. https://aspe.hhs.gov/basic-report/substance-use-disorder-workforce-issue-brief

Chapman SA, Blash LK, Mayer K, Spetz J. (2018). Emerging Roles for Peer Providers in Mental Health and Substance Use Disorders. Am J Prev Med; 54(6):S267—S274.

Faces & Voices of Recovery. Recovery Data Platform Fact Sheet. Web site fetched from https://facesandvoicesofrecovery.org/rdp/rdp-fact-sheet/

Hill, T. & White, W. (2015). Learning from other movements: Gay liberation and recovery advocacy. Posted at www.williamwhitepapers.com

Pantridge, C. E., Charles, V. A., DeHart, D. D., Iachini, A. L., Seay, K. D., Clone, S., & Browne, T. (2016). A qualitative study of the role of peer support specialists in substance use disorder treatment: Examining the types of support provided. Alcoholism Treatment Quarterly, 34(3), 337–353.

Pennsylvania Department of Drug and Alcohol Programs. (2017). House Resolution 590 of 2015 Report of the Task Force Regarding Barriers to Accessing Substance Use Disorder Treatment and Benefits. Harrisburg, PA. Pg 26. https://www.ddap.pa.gov/treatment/Documents/Hearing%20docs/HR%20590%20of%202015%20Task%20Force%20Final%20Report.pdf

The Pennsylvania Recovery Organizations- Alliance (2013). Systems Under Stress, Pennsylvania Drug and Alcohol Service System Environmental Scan. Harrisburg , PA, http://pro-a.org/wp-content/uploads/2015/01/System-Under-Stress.pdf

The Road to Recovery Discussion Guide Television and Radio Series. (2018). August Show Workforce – Training and Education. https://recoverymonth.gov/sites/default/files/roadtorecovery/august-discussion-guide-508.pdf

University of Massachusetts Medical School. (December 2018). Recovery Coaches in Opioid Use Disorder Care. Retrieved from https://rizema.org/wp-content/uploads/2019/01/UMass-Recovery-Coach-Report.pdf

Vilardaga, R.V,. Luoma, J. B., Hayes, S. C., Pistorello, J., Levin, M., Hildebrandt J., M,. Kohlenberg, M., Roget, N., A., Bond, F. Burnout among the Addiction Counseling Workforce: The Differential Roles of Mindfulness and Values-based Processes and Work-site Factors. J Subst Abuse Treat. (2011 June); 40(4): 323–335. doi:10.1016/j.jsat.2010.11.015. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3081943/

Vilsaint C.L., Kelly J.F., Bergman B.G., Groshkova T., Best D., White W. (2017). Development and validation of a Brief Assessment of Recovery Capital (BARC-10) for alcohol and drug use disorder. https://www.ncbi.nlm.nih.gov/pubmed/28578224

White, W. L. (2010). Nonclinical addiction recovery support services: History, rationale, models, potentials, and pitfalls. Alcoholism Treatment Quarterly, 28(3), 256-272.

Concept for Recovery Workforce Expansion Treatment Provider Counseling Assistant Apprenticeship Program (TPCA-Apprenticeship Program)

Phase One

- Obtain a High School Diploma or GED
- Complete the CRS Training
- Licensed Drug and Alcohol Treatment facilities that hire these persons are to follow PA Department of Drug and Alcohol (DDAP) Licensing alert 01-15 on the Supervision of Counselor Assistants

Once the individual has completed the first phase of the program they can to apply for a licensed residential treatment facility who agrees to follow the licensing alert guidelines for a supported position. If the individual has a criminal background consider bonding before disqualifying them. Please note that drug related arrests are not generally seen as disqualifications for persons working in substance use treatment facilities.

Phase Two

Interview for available positions in licensed residential treatment facilities willing to apply to DDAP for an exception in accordance with Licensing Alert 01-15 having completed the CRS training and all hiring requirements have been met the TPCA can get to work towards the position of Counselor Assistant under the DDAP staffing standards.

Phase Three

- Month 1- 3 of employment the TPCA-AP trainee is eligible to provide services to clients under the direct observation of a trained counselor or clinical supervisor in compliance with § 704.9 Supervision of Counselor Assistant as identified in licensing alert 02-15 and licensing alert 01-15 through a request for exception to DDAP at 717-783-8676 that includes a supervision plan. Please note that the exception requires that the person is actively being considered for promotion to counselor.
- Month 3- 9 the TPCA-AP trainee, contingent on the supervisor's positive assessment of the counselor assistant's skill level, they may start to counsel clients under the close supervision of a lead counselor or a clinical supervisor.

Phase Four

Months 10-36 the TPCA may counsel clients and run counseling groups

In this phase the TPCA-AP trainee must complete:

- 6000 hours of employment as a TPCA-AP Trainee
- 300 hours of supervision according to § 704.9
- 300 hours of education relevant to the field of addiction, of which 100 are alcohol and drug specific, including six in professional ethics and responsibilities.

Phase Five

The TPCA can apply to become a Certified Associate Addiction Counselor (CAAC)

PRO-A Substance Use Peer Recovery Support Service (SUPRSS)
Supervision & Recovery focused agency wellness questions to consider

Overview: *Recovery focused organizations are designed in ways that emphasis resiliency. They operate with a focus on shared decision making with an emphasis on collaborative processes. Such an orientation fosters a culture of recovery within and beyond the program. Supportive management strategies that demonstrate concern about the physical safety of workers and infuse recovery perspectives in all areas of program design and implementation are also critically important. It is an axiom that human service care systems function best when all members have meaningful input into their job duties, the patient care process and flexibility in how they carry out responsibilities. Systems that emphasis, model and embrace recovery in all areas of their operations are worth the effort to develop and sustain high quality care to develop and sustain an environment that emphasizes resiliency and growth.*

Clarity of role and function across team

- Does the SUPRSS worker have a clear role and function within the program?
- Do other program staff know what SUPRSS workers do and how their work supports program goals?
- Are the SUPRSS workers considered equal and contributive members of the care team?

Safety and inclusion of team members

- Is there attention paid to the physical safety of SUPRSS workers as they go out into the community?
- Do the SUPRSS workers have the ability to make changes to their duties in order to support their own safety and effectiveness for the work that they do?
- Is the emotional and mental well-being of all agency workers considered and discussed in supervision?

Ethics and boundaries

- Are boundaries & managing dual roles regularly discussed in team meetings and individual supervision?
- Are relevant laws, regulations and polices discussed with SUPRSS workers as part of regular team meetings and individual supervision?
- Do program managers foster an environment that encourages ongoing dialogue across the care team about potential ethical conflicts in order to improve services and ensure high standards of care?

Growth, training and education

- Are staff, including SUPRSS workers properly trained as part of orientation so that they are able to provide the duties that they are assigned?
- Is a “growth mindset” infused in the program, to ensure that there is a sustained focus on fostering a learning environment for all employees and clients?
- Are there clear pathways of advancement / use of tuition reimbursement and training to assist workers, including SUPRSS workers in advancing in their careers?

Trauma responsive / resiliency focused care

- Is self-care and support for workers emphasized at all levels of agency operation?
- Is trauma debriefing a regular process when employees are exposed to particularly traumatic events?
- Does the agency emphasis resiliency in ways that encourage team members to support each other and step in to assist each other with duties when any one member needs help or support?

WBS 6/23/19