

Office of Recovery Region 3 Community Meeting
Executive Summary and Report

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August 21st – 22nd , 2023

Realizing Recovery

Policy & Practice Improvement Series

Office of Recovery

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

This document was developed by SAMHSA's Office of Recovery, while the content and themes outlined within were identified by participants—including technical experts and those with lived experience—during the Office of Recovery Region 3 Community Meeting. Please note that the views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Office of Recovery, the Substance Abuse and Mental Health Services Administration (SAMHSA), or the U.S. Department of Health and Human Services (HHS).

A special thanks to each participant for their time and dedication towards advancing the field of recovery.

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Executive Summary

The Office of Recovery has a vital role to advance SAMHSA's commitment to and support for behavioral health recovery for all. The elevation of efforts to reduce barriers to recovery supports and advance systematic changes to promote access to mental health and substance use recovery supports is best strengthened through regional, state, and local coordination that aligns with the principles and values of recovery, while recognizing the expertise of individuals with lived experience, their families, and caregivers. On August 21st and 22nd, 2023, the Office of Recovery hosted a regional convening for SAMHSA Region 3 in Philadelphia, PA. The goal of the meeting was to engage various stakeholders at the regional level to understand variables that impact the expansion of recovery supports, identify gaps as well as discuss scalable solutions to increase recovery support integration in behavioral health systems in the local area. Approximately 75 people attended the hybrid meeting either in person or through Zoom. Subject matter experts, policy makers, people with lived and living experience, peer recovery support service providers, and harm reductionists spent a day and a half discussing the level of availability of different types of recovery support services, challenges experience while implementing and providing services, innovations in outreach and service delivery, funding issues, and diversity, equity, inclusion, and access concerns for under resourced communities.

Major highlights from the convening include:

- The need for on-going social connections virtually and in-person for the region,
- More attention and acceptance of recovery supports at various levels within state systems, funding that promotes the dismantling of system silos (i.e., mental health, substance use, and harm reduction),
- Inclusion of services for those historically under served and under resourced populations including youth, families, those formerly incarcerated, people who use drugs, and veterans,
- More housing options for people who use drugs as well as housing that supports those who want to live in an abstinence-based environment,
- More training on the inclusion of peers in various settings,
- More training on the supervision of peers, and
- The need for a common language between harm reduction, recovery, and mental health within the state system.

The following meeting summary provides a detailed account of speaker comments, participant questions and discussion from the breakout groups. A list of the participants is in Appendix A.

DAY ONE

Welcome

Kristen Harper with SAMHSA’s Office of Recovery noted that SAMHSA has launched a series of regional meetings related to recovery. The purpose of these meetings is for SAMHSA to solicit feedback from State, regional and organizational leaders on priorities and innovations related to recovery services. Jean Bennett, Regional Director of SAMHSA Region 3, also welcomed participants.

SAMHSA’s Office of Recovery Vision

Paolo del Vecchio, Director of SAMHSA’s Office of Recovery, shared his own personal story of recovery from mental health conditions, substance use disorder (SUD), and trauma. He noted that finding purpose was integral to his own journey.

He noted that over 50 million Americans are in recovery and there are many different pathways for these journeys.

We are the evidence that recovery is real and that it is the goal for all.
Paolo del Vecchio

Nationally, the issue of recovery has garnered increased attention. President [Biden’s Unity Agenda](#) referenced the recovery workforce and Congress changed SAMHSA’s Substance Use Prevention, Treatment, and Recovery Services Block Grant to incorporate recovery into the name. Further, the U.S. Department of Health and Human Services has added recovery into its overdose prevention strategy and SAMHSA has made recovery one of the four overarching principles of its strategic plan.

The vision of the Office of Recovery is to advance recovery across the nation.

In terms of activities, Mr. del Vecchio shared the following efforts that the Office of Recovery has been working on:

- Development of a [National Model Standards for Peer Support Certification](#)
- Regional meetings
- Technical expert panels on a variety of topics including warmlines, criminal justice involvement, and housing
- Diversity-focused efforts including a Tribal recovery summit convened in August 2023.

Mr. del Vecchio noted that SAMHSA supports harm reduction and will share their draft framework next month.

September is National Recovery Month, and the theme is “recovery is real.” Some of the activities that SAMHSA will be participating in include the following:

- A [Recovery Month Toolkit](#) to organize local efforts
- A Recovery Housing report (early September)
- A Recovery Luncheon in DC followed by a walk to the U.S. Capitol (September 7)
- Release of data on mobile recovery (September 20)
- A Day of Service (September 30)

Because of co-occurring primary health concerns, the average life expectancy for those with serious behavioral health issues is in their 50’s. That was the average U.S. life expectancy in the 1920s. So, we have not benefitted from the increases to longevity over the past century.
Paolo del Vecchio

One participant asked about the inclusion of family/parent support within SAMHSA's Office of Recovery priorities. Mr. del Vecchio noted there was a technical expert panel over the summer focused on family/caregivers. That discussion focused on the financial strains and other stressors faced by families.

Participant Introductions

Participants had ten minutes to do speed introductions with others in the meeting. A list of participants is provided in Appendix A.

Ms. Harper then introduced the moderator Ashley Stewart, Director of Health Equity and Racial Equity Subject Matter Expert at C4 Innovations.

States' Diverse Reaction Panel

Speakers from each State provided a general overview of their state's recovery activities.

Maryland

*Brendan Welsh, Director, Community Based Access and Support
Maryland Behavioral Health Administration*

Mr. Welsh noted that in the 1970s, Maryland was focused on institutionalizing individuals with mental health needs and in the 1990s individuals were often left on the street without support. Today, this has changed. [On Our Own](#) became one of the first peer organizations in Maryland serving individuals with mental health needs. The State also worked to get a certified recovery specialists for those with SUD. Today, Maryland has 550 peers.

Mr. Welsh noted that in 2018, Maryland's House of Delegates convened a stakeholders workgroup focused on peer reimbursement. It identified 12 recommendations that include very specific services that will become reimbursable through Medicaid.

Maryland has also used ARPA and grant funds to cover peer costs. In addition, they have peers who are focused on harm reduction (e.g., Narcan distribution and wound care). Maryland is also placing peers in prisons and has a peer in the Baltimore public defender's office.

Virginia

*Mark Blackwell, Director, Office of Recovery Services
Virginia Department of Behavioral Health and Developmental Services*

Mr. Blackwell noted that Virginia has funded consumer organizations since the 1990s. In the early 2000s, Virginia began funding five recovery community organizations (RCOs) and in 2010 conducted a system transformation initiative for recovery. The Commonwealth has always integrated the three peer types (SUD, mental health, and family) together.

In 2015, Virginia's Office of Recovery Services was established to support workforce development (quantity and quality); oversee certification; and pursue Medicaid billing. The Office added problem gambling into their portfolio.

Regarding recovery housing, Virginia has over 150 houses which translates to over 3,000 beds. They have an overdose prevention program known as [Revive](#) and have been striving to be forward thinking in other harm reduction efforts.

Mr. Blackwell also noted that they have eight universities with collegiate recovery programs and that Virginia Commonwealth serves as a Center of Excellence. The Commonwealth will be opening their first recovery high school soon.

West Virginia

*Elliot Birckhead, Deputy Commissioner, Programs & Policies
West Virginia DHHR/BBH*

West Virginia has been supporting peers since 1990 and leveraged SAMHSA's mental health block grant towards building their statewide peer network. Their work has been more focused on local and regional oversight.

The State has a network of drop-in centers and a network of Recovery Community Organizations (RCOs) and was able to get a Medicaid waiver to cover SUD (and co-occurring services), though the waiver does not cover mental health-only services.

The State Medicaid office had developed a certification for peers, but it got rejected as being too rigorous. So, they have developed a modified online certification test. Now in West Virginia the Medicaid peer recovery certification has merged with the WV Certification Board for Addiction and Prevention Professionals so there is a single state peer recovery support services certification.

Mr. Birckhead also shared that West Virginia used their SOR funding to place peers in jails, quick response teams, and maternal-child hospitals. The State has collegiate recovery programs and ONDCP has created an opioid prevention program for high school students. In terms of social determinants, the State has housing programs (National Alliance for Recovery Residences and Oxford Housing); funds transportation needs: and is partnering with a Governor's program to address employment barriers.

Pennsylvania

*Sam Swarbrick, Chief Strategy Officer,
Pennsylvania Drug and Alcohol Programs*

Pennsylvania has reviewed evidence-based practices to be more thoughtful on where to invest funding. There is a State Recovery Department, as well as nine regional recovery hubs. The State operates a hub and spoke approach for service delivery so that they can have more community-based coordination which they feel will improve DEI efforts. The recovery hubs may or may not be centered by a recovery community organization. There are a few county agencies that act as the hub for the spokes.

Pennsylvania has both high school and collegiate recovery support. While they do harm reduction (e.g., Narcan, wound care and Fentanyl test strips) the State is working to elevate this priority and further build out services.

Pennsylvania has two, separate peer support programs. One program is led by the Department of Drug and Alcohol Programs and the other by the Office of Mental Health and Substance Abuse Service (OMHSAS).

Delaware

*Karen Records, Chief of Social Determinants, Delaware
Division of Substance Abuse and Mental Health*

Delaware is a small State, so services are centralized. However, the adult and child-youth behavioral health services are separate departments. Their peer certification is through the International Certification & Reciprocity Consortium (IC&RC). They have a certification pathway for correctional peers and currently have eight inmates participating in a pilot program.

The Division of Substance Abuse and Mental Health supports peer recovery and social determinants support services. Currently, they are analyzing their peer job description to determine how to address peer drift and workforce shortages.

They have also focused on ensuring that there is a more seamless continuum of care. Delaware has developed a DEI and community well-being ambassador program. Regarding social determinants, the state recently passed a bill that requires recovery housing to be certified and to support transportation, education, employment, and legal needs. The State also has a [“fruit and vegetable” prescription program](#) to improve nutrition, particularly for individuals experiencing homelessness.

Discussion

As the moderator, Dr. Stewart provided some guidance questions.

With regard to your State’s recovery support services, what’s working exceptionally well?

- **Maryland** – The amount of diversification and flexibility of funding. For example, funding now also allows stimulant use disorders to be addressed.
- **Pennsylvania** – Silos are being broken down and recovery services relate to prevention and treatment programs. The funding has encouraged these connections and allowed for a rapid lift of programming.
- **Virginia** – The Commonwealth used their pandemic funds to expand to different peers. Specifically, Virginia has a 72-hour basic training and then developed advanced training.
- **Delaware** – The additional funds weren’t enough to support their recovery housing needs. However, Delaware was able to establish apprenticeships for both supervisors and peers across the continuum.
- **West Virginia** – While the pandemic created significant loss of life, it did also show the importance of connection. As is often said in this profession, “the opposite of addiction is connection.”

What are some of the challenges you face?

- **Pennsylvania** – Mr. Swarbrick cited workforce issues at “every level.” They have limited career growth and low pay. There is also a need to improve the warm handoffs. Mr. Swarbrick noted that there is buy-in for recovery activities, but more is needed to educate on the implementation.
- **Maryland** – Mr. Welsh noted that he would like to see funding and resources available to help with peer self-care. The State also struggles with siloed funding and trying to support the whole person. Lastly, he noted that there is peer drift so that peers are not being employed correctly. He noted that more clarity of roles is needed.
- **West Virginia** – West Virginia is trying to provide more education to address stigma related to harm reduction and the use of medication for opioid use disorder (MOUD).
- **Virginia** – Mr. Blackwell noted that there are still regulations that preclude some peers with criminal justice involvement from being employed.
- **Delaware** – The workforce shortage is an issue. There is burnout, stigma, and turnover. Delaware used a grant to help them create a career ladder. Another concern is housing. There is a lack of landlords, zoning issues, and stigma. Most grants only cover staffing but not brick and mortar needs. Delaware is convening an equity summit because people of color are still not accessing services.

What is working well in terms of providing social determinants of health and building recovery capital from a DEI perspective?

- **Maryland** – The department had a director who championed DEI. They have focused on LBGTQ+ populations as well as veterans. Mr. Welsh noted that just using peers helps improve the diversity of the workforce.
- **Pennsylvania** – The hyper localized approach allows for geographic cultural approaches and a focus on more marginalized pockets across the State.
- **West Virginia** – Their most effective strategy has been to partner with community-based organizations that serve BIPOC communities. These organizations have better reach and are trusted. In addition, they can provide advocacy on their needs. Entities that they work with are LBGTQ+ groups as well as the Association of Black Churches.
- **Delaware** – Ms. Records noted that the State feels the best way to support DEI needs is to elevate community-based organizations (CBOs) and help them to build partnerships with clinical staff. As an example, they have a Haitian community that they are trying to expand access to services for.

Participants then had an opportunity to provide questions and comments.

- **Recovery High Schools** – Tiffinee Scott noted that Baltimore City has a desperate need for a recovery school. They have staffing and infrastructure but don’t know how to get funding for the building. Mark Blackwell shared that it has been champions in the system that have been most impactful.

- **Length of Stays for Recovery Houses** – In response to a question, Ms. Records noted that individuals can stay in transitional housing for up to two years. However, the average has been 90 days.
- **Funding for Beds or Positions** – It was clarified that funding for transitional housing was for staff positions not the beds.
- **Sustainability of Services** – Mr. Welsh said that he doesn't believe that fee-for-service is the right answer, but there needs to be sustainability and also services need to be equitable.
- **Peer Supervisors** – Delaware and Virginia use peer supervisors. Pennsylvania is exploring that option. Maryland recently allowed for non-clinicians to supervise peers (except in FQHCs).
- **Non-Abstinent Housing** – Dan Buckley asked about recovery housing for those that aren't in abstinent recovery. Ms. Records stated that Delaware provides rental assistance and vouchers. Landlords are sometimes reluctant to accept the vouchers, so individuals often are placed in hotels. Mr. Birkhead noted that this is the main force behind Housing First programs.

State Breakout Groups

Participants then met in breakout sessions to discuss diversity, equity, inclusion, and social determinants of health (SDOH) related to the following questions:

- What is going well in your local community?
 - What is going well in the region?
 - What is going well nationally?
- Where do we (the MH 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 breakout reports from the States.

Delaware

Efforts Going Well

- An expanding peer workforce.
- Ability to centralize the peer program across the State.
- Using data to drive health equity advancements.
- More funding opportunities for non-traditional partners.
- An acknowledgement that recovery services are part of the continuum.

Progress Still Needed

- More data to help justify recovery services and identify those programs that are evidence-based.

End Goal and Innovation

- A national integration of recovery as part of a continuum of care (e.g., not a carve out).
- Discretionary grants to help ramp up the recovery infrastructure.

District of Columbia

Efforts Going Well

- A diversity of cultures.
- The national focus on SUD and mental health as a public health crisis.

Progress Still Needed

- More support to the Hispanic, LBGTQ+ and veteran communities.
- More focus on youth services as well addressing the intergenerational and family impacts.
- More prevention services. Children’s Hospital is seeing an uptick of cases.
- Marijuana is legal and has a saturated presence. But youth can’t go to the dispensary, so they are buying on the street.
- More family-focused supports.
- Development of a youth recovery school.

End Goal and Innovation

- A more robust system that applies a population health approach across the age spectrum.
- Family operated centers and youth peers that are built into the system.
- System for differing youth ages (e.g., middle schoolers separate from high schoolers).

Maryland

Efforts Going Well

- Increased diversity of the workforce.
- Leadership and State personnel are also diverse.
- More intentional trainings for underserved communities (youth, LBGTQ+, senior, and those who are criminally-justice involved). They have 42 peers over the age of 50.
- Peer workforces located in hospitals, social service entities and services for pregnant and parenting individuals.

Progress Still Needed

- To expand family peer support.
- More transportation support in rural areas.
- Addressing the digital divide.
- Significant differences across county lines. The State participants would like to see service be available across the county lines with counties strengthening support of each other.
- More peers for child and youth needs (e.g., early onset).

End Goal and Innovation

- Technical assistance to peer organizations to help them acquire funding.
- Assistance to peer organizations to build their capacity and maintain sustainability.
- Systems that better understand peer roles and address peer drift.
- More peer respites.
- Providers create safe space and support for peers and supporting peer respites. This includes addressing compassion fatigue and emotional safety for the peer workforce.

Pennsylvania Group One

Efforts Going Well

- Helping individuals with advocacy as well as advocacy for the field of recovery.

Progress Still Needed

- Counties have autonomy so the State struggles to provide oversight or standardization.
- Silos across SUD, mental health, and physical health. Also silos across the age continuum.
- Addressing stigma.

End Goal and Innovation

- Using our resources to create bench strength to help move the field further.

Pennsylvania Group Two

Efforts Going Well

- RCOs more diversified.
- More attention to the services and increased funding.
- Regional Recovery Hubs.

Progress Still Needed

- The need for consistent reliable funding.
- Juggling future plans with survival needs now (e.g., tension).

End Goal and Innovation

- Tackle stigma which is baked-in the systems.
- More BIPOC-led RCOs.

Virginia

Efforts Going Well

- Staff hired specifically to address DEI concerns. DEI is part of trainings and incorporated into manuals.

Progress Still Needed

- More effort to ensure that those who are in decision making roles (i.e., at the table) represent the people that are being served.
- State systems and organizations to dismantle the systematic racism aspects that exist internally.
- Support to peer organizations, particularly for Black, African, African Americans, and indigenous populations. There should be technical support to them rather than poaching their staff within State systems.

End Goal and Innovation

- Human dignity for all.
- More programs at the community-level.
- Sustained policy change to reflect the vision of peer services.
- Jails, shelters, and morgues no longer filled with individuals with mental health and SUD needs.
- Stronger regional relationships.
- Stronger relationships with the BIPOC communities.
- Funding options to support innovation at the local level.

West Virginia

Efforts Going Well

- Education of staff on DEI concerns and needs (partnerships with the YMCA and Black, African, & African American churches).
- Emotional intelligence and unconscious bias training with police and corrections staff.
- Marshall University's [Center of Excellence for Recovery](#).
- The use of peer hubs.
- The data collection system.

Progress Still Needed

- Better reentry services prior to release.
- Better education and liaising with correctional staff.
- Transitional housing for those individuals not in recovery.
- Credentialing for mental health peers.
- Sustainable funding. Collegiate recovery programs are impactful but not a sustainable model.
- More housing and employment options for those in recovery.
- Have myth-buster sessions to reduce the stigma that policymakers have about peers, individuals with behavioral health needs and recovery.
- Addressing peer burnout and compassion fatigue.
- Professional assistance for peers (like what is provided for lawyers and doctors).

End Goal and Innovation

- Access to resources in a timely manner across the full continuum of care.
- Model of care for our workforce. This includes appropriate supervision but also other innovations.

We need to take better care of those [peers] who care the most for others.

Deb Harris

Zoom Group

Efforts Going Well

- Training of specialized peers (LBGTQ+, older adults).
- The use of peers to expand the diversity of the workforce.
- DC had a lot of success with community education series, helping address system, trauma helpful for those in recovery, as well as family and the public.
- Pennsylvania has a social determinants of health payment program that provides transportation, food, diapers, etc.

Progress Still Needed

- A need for more virtual services and services for families.
- While it is great that there is so much discussion about peers, there needs to be a consistent stance on the implementation and outcome.
- The difficulties of siloed funding.
- Peer drift (e.g., not asking peers to drug test or serve as sponsors).
- Being more trauma informed. And having clarity on boundaries and safe spaces.
- Build up an appropriate supervision approach.
- Housing for those that may still be using substances.
- Language and specifically ensuring that mental health is incorporated into recovery efforts.
- Addressing workforce development (career advancement, peers, etc.).
- A disparity between those who are in recovery and those in recovery who are employed.
- Stigma around mental health in the workforce.
- Providing a livable wage.

End Goal and Innovation

- Clinicians know what recovery is and the supports to provide.
- Peers participate fully in patient or client service meetings, have their input included in patients' notes and are involved in decisions and development of policies.
- There are sustainable resources and funding.
- Families are regarded as a safety net rather than a problem.
- Make SUD and mental health treatment aesthetically welcoming like birth centers and cancer treatment facilities.
- There are programs to address stigma.

- There is ongoing cultivation of recovery champions.

DAY TWO

Dr. Stewart shared the following themes from Day One discussions:

- **Strengths** – Social connections virtually and in-person; more attention and acceptance of recovery at various levels, and funding to States have been diversified.
- **System Silos** – Mental health, substance use, and harm reduction.
- **Populations Needing More Attention**– Those systematically marginalized, youth, family, formerly incarcerated, people who use drugs, and veterans.
- **Housing** – Need housing options for people who use drugs, Housing First funding different from recovery housing, not enough housing options for those individuals with SUD who want to live alone and independently.
- **Peers** – Authenticity of peers, funding peers, supervision (clinical vs. senior peers), career ladders, pay scale, confusion of roles of peers in various settings, barriers for peers to become certified and/or hired, and requirements to be certified.
- **Innovations** – There were several innovations shared yesterday such as Delaware’s wraparound approach for addressing social determinants and Pennsylvania’s regional RCO hub and spoke model.
- **Language/Terminology** – SUD recovery, mental health recovery, overdose prevention, harm reduction. Is the field using different words to mean the same thing? And is the field using the same word to mean different things?

Participants then had an opportunity to provide questions and comments:

- **Across-State Collaboration** – Many States are facing the same challenges so having collaborative opportunities and conversations like this are helpful. Specifically, one State’s innovation can help other States.
- **Non-Recovery Transitional Housing** – One participant shared that this reference yesterday was the first time she had heard of the term and the needs.
- **Not Being Alone** – Yesterday was like that moment when an individual walks into a recovery meeting and realizes they are not alone. It was helpful to hear that other States are dealing with the same struggles and that there are some solutions that they can share.
- **Special Circumstances of the District of Columbia** – Because it isn’t a state, DC is often left out, so it was good to be included. There are also some unique needs because DC is under the authority of Congress for some funding/regulations.
- **Youth** – There were several references to young adults’ needs. They should also be invited to the table and included at gatherings like these.

Recovery Services in Various Settings

In this panel, speakers from different recovery settings (e.g., RCOs, collegiate recovery programs, associations, training organizations) shared their perspectives on what they have been doing and the challenges that they have faced.

They began with an introduction of their work and the community they serve.

Kathy Quick

Dr. Quick is the Executive Director, [Pennsylvania Mental Health Consumers' Association \(PMHCA\)](#), and a person in recovery for a co-occurring disorder and suicide attempt. She noted that education served as a healing tool for her. PMHCA is a Statewide organization that advocates, educates, and promotes recovery. They also provide referrals. Some of their activities include the following:

- **The Rainbow Peer Project** – This is a training program for supporting the LGBTQ+ community.
- **Police Co-Responder**– There is one county that uses a co-responder approach with peers accompanying police on every call.
- **Youth Move** – PMHCA supports their sources of strength program which is an evidence-based practice for addressing SUD and suicide risk. It helps to create a positive atmosphere of acceptance within schools.

Eula McMillan

Ms. McMillan is a Recovery Coach with [Lost Dreams Awaken Center](#), an RCO based in Pennsylvania. They have a focus on harm reduction and Ms. McMillan noted that they address relapse in a non-stigmatizing way. She added that when the pandemic happened, they relied primarily on telephone support. She emphasized the importance of getting an individual's phone number stating that staff will often follow up by phone for those individuals that don't return to the program. This persistence does translate into improved participation.

I had a return to use after 20 years of recovery. The organization leadership didn't give up on me and that is why I'm here today.

Eula McMillan

Honesty Liller

Ms. Liller is the CEO of the [McShin Foundation](#) an RCO and recovery housing referral entity based in Richmond, Virginia. They have 16 recovery homes as well as a recovery center. Ms. Liller credited the organization for “saving my life” and allowing her to regain custody of her daughter. In term of housing, they have specialized housing for parenting and pregnant moms as well as housing for those who have been involved in the criminal justice system.

Heather Orrock

Ms. Orrock is the Executive Director of [Vocal Virginia](#) which provides a range of trainings that include policy advocacy, trauma-informed practices, and anti-racism approaches. It is the only statewide mental health organization that is 100% peer run. Vocal Virginia has three pillars of programming: advocate, train and collaborate.

Susie Mullens

Ms. Mullens is the Program Director for the [West Virginia Collegiate Recovery Network](#) based out of Marshall University. The network has been funded through the SOR grant and spans across nine schools, including one medical school and several technical colleges. Seven of the schools include students who are criminal justice-involved and many also do outreach to the larger community, including distribution of Narcan and Fentanyl strips.

Students are known as *Ambassadors for Recovery on Campus*. The network also has a community ally that hosts a [Recovery Roast](#) event with the proceeds being used to provide scholarships to students in recovery.

Tiffinee Scott

Ms. Scott is the President of the [Maryland Peer Advisory Council \(MPAC\)](#) which is a peer-run advocacy, outreach & training program for individuals, families, and allies. She noted that the opioid epidemic has hurt her family significantly. Both her parents had an active addiction and then recovery and she lost two children to the epidemic. Her main work has been to tackle the barriers within systems so that there is more access for individuals in need. Ms. Scott is also the Vice President for [the Maryland Addiction & Behavioral-Health Professionals Certification Board](#).

Kim Jones

Ms. Jones is the Deputy Director of the [Community Collaboration of Delaware \(CCCD\)](#) which aims to foster collaborative opportunities to provide sensible community-based solutions for individuals in recovery. Ms. Jones noted that she had previously served at a sober-living house and realized that many of the other services (treatment, job-skills training, etc.) were lacking so that individuals were ill-prepared for transition.

She noted that individuals in recovery come from all walks of life. For example, she was formerly incarcerated in a federal facility and four employees there ended up graduating from her program. It is important for individuals to see this diversity to address stigma and promote hope.

Individuals want to see not just that they can have a job, but a career.

Kim Jones

Discussion

As the moderator, Dr. Stewart provided some guidance questions.

With regard to your program and services, what's working exceptionally well and/or has been most impactful?

- **Almost Same-Day Recovery Housing** – Ms. Liller shared that they have received several SAMHSA grants and have expanded from 3 to 16 recovery homes. The programs teach recovery and life skills and there is also peer training. She noted that there is a new home for pregnant and parenting individuals which was named after her daughter who was born with neonatal abstinence syndrome (NAS).
- **Collaboration between Community and Local Government** – Ms. Scott noted that Local Behavioral Health Authorities (LBHAs) in Maryland are more open to supporting the role of CBOs, many which are peer-led.
- **Paid Peers** – Ms. Scott also noted that Maryland’s peer workforce was predominately volunteers but now more are being paid for their work.
- **Use of Multiple Funding Streams** – Ms. Orrock stated that Virginia’s Office of Recovery Services has helped the workforce to expand with multiple funding streams. These additional funds have been used to fund Vocal Virginia’s action plan and have enabled peers to be placed in additional locations, such as hospitals, the crisis center and post-crisis providers. They are also working towards peers being placed into Certified Community Behavioral Health Clinics (CCBHCs).
- **Leaning Into Uncomfortable Truths** – Dr. Quick said that PMHCA has been having local conversations led by individuals who have attempted suicide. These are very uncomfortable but important stories and incorporate a lot of discussion about trauma. She noted that many have trauma knowledge, but more work is needed to be put this knowledge into practice.
- **Talking About Stigma** – Dr. Quick emphasized that self-stigma is common and there is a need to address stigma from providers, decisionmakers, those in the criminal justice system, and the public. The media also reinforces stigma in the way they cover acts of violence.
- **Provider and Service Agency Collaboration** – Because of its small size, Delaware providers and service agencies know each other, making it easier to collaborate.
- **State Alliance of Recovery Housing** – The Delaware legislature [passed House Bill 114\(S\) a bill](#) for certified recovery house and Delaware will have a State-wide alliance for recovery housing.

Stigma is overwhelmingly alive and well.

Kathy Quick

What are the State and Federal funds that are most needed?

- A full system of care for pregnant and parenting individuals.
- Transportation. We would love to purchase a van.
- More collegiate recovery programs and a sustainable source. College enrollment is down so colleges are reluctant to invest in these programs.
- Support for harm reduction, housing, and daycare support.
- Better support for our peers, including a living wage, health benefits, and a safe work environment.

- Community-based services across the sequential intercept model (SIM).
- Peer respite as this can reduce crisis needs.
- Administrative infrastructure for smaller organizations so they can apply for grant funds.

What does authenticity look like and how does that change services that we provide?

- Reminding ourselves where we came from and why we are doing this work. It is easy to get caught in the day-to-day tasks.
- Having patience with individuals who are self-sabotaging and remembering that someone may have been patient with us in our early recovery journey.
- Struggling with the tension of pursuing direct care funds (e.g., Medicaid) without compromising our role of nurturing relationships with our clients.
- Being transparent and honest. Meeting the person where they are even in the painful spaces (e.g., at court, having their child removed from their custody).
- Continuous training and reflections.
- Having peer organizations practice what they preach in terms of providing a trauma-informed workplace with self-care opportunities.
- Providing fun activities. Teach a person in recovery that life is worth living.
- Bring those in early recovery with you when you do advocacy. Make it as participatory as possible.
- Help new peers with soft skills like literacy and computer skills.

How do you incorporate different philosophies of recovery (e.g., MAT, harm reduction, etc.)

- While we are a 12-step model, we recognize multiple pathways. We store MAT and have a methamphetamines anonymous program. We recognize the world has changed and try to stay educated so our peers can accommodate the different needs.
- We aspire to a “whole person” approach, so we include primary health needs like nutrition. If we can’t provide the service, we will try to find a referral for the client.
- An individual can come into our center without wanting services. They can just sit, have a cup of coffee, play the drum. It is also important to operate beyond a 9 to 5 schedule. Any engagement that brings the individual in has value.

How do you deal with not-in-my-backyard (NIMBY) attitudes of neighbors related to recovery housing?

- Be good neighbors and stewards. We join community events, have park clean-up efforts, and focus on communication/education. In one instance, a critic was asked if she could identify which of the houses on the street were the recovery house and she couldn’t. Ms. Jones did share that is disheartening to deal with these issues. While you can’t change everyone, these approaches can help.
- In Maryland there has been historical support for recovery housing, particularly in Baltimore. There is an advocacy group (The Maryland Association for Supportive Housing) which provides education on how to operate good recovery housing. As a byproduct, it has built people power and entities have been educated.

- There is a [Recovery Bill of Rights](#).

Sometimes RCOs see a gap in service and then try to provide it. How do you prevent mission creep? And how do you build sustained partnerships?

- There was an example where we wanted more connection with jail programs. We had kept asking and didn't get a response. So, we sent over BBQ sandwiches and now have a relationship with them. It is important not just to seek out relationships but also nurture them, so they are sustainable.
- Pennsylvania was awarded a recovery hub grant and the recipients are required to identify all the providers in the region, create a community, and develop a needs assessment. Most organizations want to be part of a community network.
- There was a coalition that met about hospital onboarding. The discussions were contentious. However, out of that discussion, the participants agreed to continue to talk and support each other. They have met monthly for several years. If there are opportunities, the organizations will do advocacy together.
- In 2020, there were several libraries that had an increase in incident reports. So, peers began to provide a presence at these locations to help with resources and program navigation. It was noted that many library patrons were food insecure and lacked access to digital services. So, there are a partnership with the [Hunger Free Zone food truck](#) and efforts to provide more computers and hot spots.
- The “no wrong door” policy has been around for more than a decade. [Misha House](#) only does housing. So, to provide other services, partnerships are needed.
- We also outsource services. This includes providing MAT. One example is partnering with the University of Delaware's nutrition clinics where individuals got to visit the demo kitchen. We also have a partner that provides sex education since many participants have misinformation.

Breakout Session

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

- What is going well in your local community, region, nationally?
- Where do we (the MH 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.

Delaware

Efforts Going Well

- Peers are credentialed, valued, and integrated across the State.

- There is easier access to peer and peer supervision trainings.
- They have made progress in identifying sustained funding for peer certification.
- They have expanded apprenticeship opportunities for individuals who are not yet certified.
- Delaware has a [Project Echo program](#) for peer recovery specialists.

Progress Still Needed

- More equity for medications besides MAT.
- Increased training for peers related to ethics. This is particularly important for the younger peers and the availability of social media access.
- Address peer drift and setting boundaries.

End Goal and Innovation

- This should be a continuous process with no end goal.
- Standardized pay scales.
- Innovative payor models other than Medicaid which is unwieldy and low pay. Perhaps some innovative work with Managed Care Organizations.
- Sharing national evidence-based practices and a toolkit to help with advocacy to local legislators.
- Identifying the data that is relatable to peers and how they measure success.

District of Columbia

Efforts Going Well

- Strong provider network, but not enough peers to meet the demands.
- Peers have a strong recovery knowledge base.
- There is a support network for peers.
- DC is in the process of developing a Peer Academy.
- Peers are embedded with EMTs and Fire Department staff as well as in emergency departments.
- Peers do ride-a-longs and try to instill compassionate care for individuals.

Progress Still Needed

- Some providers don't feel confident in supervising peers and fear they might do a disservice by exposing them to secondary trauma.
- DC wants to have forensic peers.
- They also want peers for families, older adults, and youth.

End Goal and Innovation

- Peers are embedded in all places.
- Wellness includes more than just physical health.
- Behavioral health discussions begin at a young age.

Maryland

Efforts Going Well

- More organizational buy-in for using peers in a variety of settings (e.g., behavioral health organizations, jails, libraries).
- The Maryland Peer Advisory Council and On Our Own are strong peer-run entities.
- Maryland's [Center of Excellence on Problem Gambling](#).
- The [Maryland Coalition of Families](#) is a strong specialization community.
- Multiple pathways to recovery are available and respected.

Progress Still Needed

- Maryland has expanded the career ladder from two to five positions. However, the LBHAs and providers need more education on base salaries and job descriptions.
- Peers need to be offered more soft skills.

End Goal and Innovation

- To have our organizations and peers trained around the implementation of peer support so that they are utilized for maximum benefit.
- Expand the use of peers beyond behavioral health settings.
- Continue to collect and use data that's aligned with peer support to identify the innovative supports moving forward.

Pennsylvania Group One

Efforts Going Well

- There are peer respites which help to divert individuals from emergency rooms.
- There is data collection done upon intake and at the 30-60-90 day post-service.
- The State has 500 peers in corrections, and they have been enhancing the training.

Progress Still Needed

- Peer respites need more sustainable funding.
- Improved systems and data to better inform decisions. There is still a lot of redundancy of records and administrative burden.
- More consistencies in the training and certification for mental health and SUD peers.
- There are barriers so that some peers who get trained can't get certified.
- Wages are low and the work is stressful. Mr. Puskaric shared that he relapsed because of the stresses of his role.

Peers are putting their lives and recovery at risk in this work.

Kevin Puskaric

- Burn out and fatigue.

End Goal and Innovation

- Peer support is accessible to everyone, not just individuals with diagnosis or substance use disorder. It would be available regardless of insurance.

Pennsylvania Group Two

Efforts Going Well

- Community being educated to understand that there are a variety of recovery pathways.
- SAMHSA's Office of Recovery has been a game-changer.
- Harm reduction is a normal part of the conversation.
- Funding has increased.
- The power of storytelling which is our "superpower."

Progress Still Needed

- Peers leverage their own personal recovery story. There is a cost to that. More wellness and safety is needed for peers in these settings.
- Peers need benefits and job stability.
- Those who are not certified peers may find sharing their recovery story creates stigma, particularly for their career.
- Because of the large size of the State, it is hard to convene all the stakeholders together.

End Goal and Innovation

- There is more of an emphasis on the wellness of the workforce and to not employ a burnout model in the way systems employ workers.
- Systems need to invest in peers, in addition to monetary incentives.

Virginia

Efforts Going Well

- The State has incorporated addressing problem gambling in their work.
- They have had a peer ladder for the past three years.
- Peers are embedded in many locations including with EMTs and emergency departments.
- Offering training on the peer workforce (self-care needs).
- Improved integration of SUD and mental health services, though more efforts are needed.
- There is a growing recognition and appreciation of peer support (some jurisdictions are more receptive than others).
- The national conversations help undergird these efforts.

Progress Still Needed

- More of a wellness focus.
- Setting boundaries for peers and addressing peer drift.
- Continue in building connections and collaborations.
- Expanding peer support to avoid tokenism.
- Lower caseloads.
- Having safe spaces for peer sharing.
- More leadership support.

End Goal and Innovation

- Peers have a trusted space and collaborative partners to do their work.
- A national peer support system which provides confidentiality. This can't be done at the local level.

West Virginia

Efforts Going Well

- The number of peers has grown substantially.
- Peers are valued.
- 13 collegiate recovery programs.
- The [Jobs and Hope program](#) to support employment.
- West Virginia convened a statewide peer conference which was particularly meaningful for those that work in remote rural settings.
- West Virginia's Office of National Drug Control Policy has sponsored peers in a variety of non-traditional settings.
- Conversations about data collection, particularly information about return on investment.
- They have a [Save a Life Day](#) through SOR funds to distribute naloxone.

Progress Still Needed

- A need for more consistency for the peers training.
- More RCOs.
- Sustainable funding.
- More drop-in centers and peer respites.
- A peer assistance program like what is offered to lawyers, doctors, and nurses.

End Goal and Innovation

- Peers are part of the continuum and there is no longer a continuous need to justify their existence.
- People in recovery learning how to live, not just about being sober.
- Having return on investment demonstrated.
- There is collegiate recovery.
- There are more job opportunities.
- More free naloxone, particularly, [West Virginia's One Box](#).



West Virginia's One Box Naloxone Kit

Zoom Group

- There is more integration and also acceptance from the general public.
- Wellness is incorporating more than just physical health (e.g., social networking and emotional help, financial).
- “Dignity of risk” and having acceptance regardless of the prior choices that have been made.
- What do peer services look like? How are they being recognized?
- Certification is important but there needs to be a marriage between authenticity and professionalism.
- More education and funding are needed to address social determinants. There is still stigma about these services.
- More education about wellness, particularly for individuals with serious mental illness.

Wrap up and Next Steps

Dr. Bennett shared a personally painful story of losing a relative who was in recovery but may have experienced secondary trauma from her work with a 988 call line. She noted that SAMHSA Region 3 staff are here to support States and that she also is concerned about the well-being of the peer workforce.

Dr. Stewart thanked participants and noted that many of the discussions at this meeting help to honor the stories of those that are not able to speak. Mr. del Vecchio stated that while much work is still needed, there has been a lot of progress in these last few years.

Ms. Harper thanked participants and noted that a report will be generated. She will share it with participants for review.

A summary of the resources referenced is listed in Appendix B.

About the Realizing Recovery Series

To advance recovery across the nation, the Office of Recovery 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—ranging from strengthening the general peer workforce to advancing recovery across tribal and justice-involved communities—aligns with a particular 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, 2025, and beyond; but also provides SAMHSA, the Office of Recovery, 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 that are part of the Realizing Recovery Series, please visit <https://www.samhsa.gov/find-help/recovery>.

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

**Attended virtually*

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PENNSYLVANIA

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Appendix B: Summary of Resources

SAMHSA

- [National Model Standards for Peer Support Certification](#)
- [Recovery Month Toolkit](#)

Delaware

- Well-being Ambassador Program
- [“Fruit and Vegetable” Prescription Program](#)
- Wraparound Approach for Addressing Social Determinants
- [Community Collaboration of Delaware \(CCCD\)](#)
- State Alliance of Recovery Housing
- [Certified Housing Legislation](#)
- [Project Echo program](#) (for peer recovery specialists)

Maryland

- [Maryland Peer Advisory Council \(MPAC\)](#)
- [Maryland Addiction & Behavioral-Health Professionals Certification Board](#)
- [Hunger Free Zone food truck](#)
- [Misha House](#)
- [On Our Own](#)
- [Center of Excellence on Problem Gambling](#)
- [Maryland Coalition of Families](#)
- Maryland Association for Supportive Housing (MASH)

Pennsylvania

- Regional RCO Hub and Spoke Model
- [Pennsylvania Mental Health Consumers' Association PMHCA\)](#)
- Rainbow Peer Project
- Police Co-Responder (in one county for all calls)
- [Lost Dreams Awaken Center](#)

Virginia

- [Revive](#) (overdose prevention program)
- [McShin Foundation](#) (RCO and recovery housing referral)
- [Vocal Virginia](#)

West Virginia

- [Opioid prevention program](#) (for high school students)
- Marshall University’s [Center of Excellence for Recovery](#)

- [West Virginia Collegiate Recovery Network](#)
- [Recovery Roast](#) (fundraiser)
- [Jobs and Hope program](#) (employment)
- [Save a Life Day](#) and [West Virginia's One Box](#) (Narcan distribution)

Other Entities

- [Youth Move](#) (advocacy)
- [Recovery Bill of Rights](#)
- [Sources of Strength](#) (program)