



Office of Recovery Region 5 Community Meeting

Executive Summary and Report

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Realizing Recovery
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Office of Recovery
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This document was developed by the Substance Abuse and Mental Health Services Administration's (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 5 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, 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.

Table of Contents

Executive Summary	4
Opening Remarks.....	5
Overview of SAMHSA's Office of Recovery	5
Participant Introductions.....	6
State of Recovery in Region 5	6
State Representatives Reactions.....	8
Ohio	8
Michigan	8
Illinois	9
Minnesota.....	9
Breakout Session.....	11
Minnesota.....	12
Illinois, Indiana, and Wisconsin.....	12
Michigan and Ohio	13
Zoom 1	14
Zoom 2	15
Final Thoughts	16
Recovery Services in Various Settings	18
AJ French.....	18
Mike Durchslag.....	18
Tim Saubers	18
Brandon George	19
Ahmed Hosni	19
Pam Werner	19
Breakout Session.....	21
Zoom 1	22
Zoom 2.....	23
Illinois and Wisconsin.....	23
Michigan and Ohio	24
Minnesota.....	25
Prioritization Activity	25
Wrap up and Next Steps	26
Appendix A: Participant List	28
Appendix B: Region V Peer-Related Activities	32

Executive Summary

The Office of Recovery has a vital role to advance SAMHSA's commitment to and support of 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. Diverse discussions that align with the principles and values of recovery, while recognizing the expertise of individuals with lived experience, their families, and caregivers, creates an opportunity to explore various priorities facing the region. On August 8th & 9th, 2023, the Office of Recovery hosted a regional convening for SAMHSA Region 5 in Chicago, IL. 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 50 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 (or service providers who utilize a peer support model), and harm reductionists spent a day and a half discussing the level of availability of different types of recovery support services, challenges experienced while implementing and providing services, innovations in outreach and service delivery, funding issues, diversity, equity, inclusion, and access concerns for under-resourced communities.

Major highlights from the convening include:

- Examine funding options as well as develop philanthropic innovations to fund recovery in the region,
- Ensure integrity of peer delivered services by developing quality assurance measures,
- Develop a broad data strategy that extends beyond peers and focuses on underserved and under resourced populations receiving recovery support services,
- Include historically marginalized communities who have been left out of decision-making conversations at the state, regional, and federal levels, and
- Cultivate more of a focus on whole person wellness utilizing SAMHSA's dimensions of recovery: community, home, health, and purpose.

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

Opening Remarks

Kristen Harper with SAMHSA's Office of Recovery noted that SAMHSA has launched a series of regional meetings related to recovery and Region 5 is the inaugural gathering. The purpose of the meetings is for SAMHSA to solicit feedback from state, regional and organizational leaders on priorities and innovations related to recovery services.

Lynda Zeller from SAMHSA's Region V Office also welcomed individuals on behalf of Regional Administrator Captain Jeff Coady.

Michael Cabonargi, Regional V Director for the U.S. Department of Health and Human Services (HHS), shared that HHS has a number of grants in the pipeline, including grants specifically focused on workforce development. He acknowledged the issues of burnout and recruitment/retention of peers.

Ms. Harper then introduced the two meeting moderators: Keith Murphy, Director of Alcohol and Other Drug Assistance Program at Rutgers University; and Brandy Brink, Founder and Director for WEcovery, a Recovery Community Organization (RCO) in Minnesota.

Overview of SAMHSA's Office of Recovery

CAPT Wanda Finch, Special Expert in SAMHSA's Office of Recovery, provided a brief overview of SAMHSA's mission and launch of the Office of Recovery. Specifically, she noted the following:

- **Deep Recovery Roots** – While SAMHSA's Office of Recovery is less than a year old, SAMHSA has been engaged in partnerships with families, communities, and individuals on recovery services for over two decades.
- **Multiple Pathways of Recovery** – Recovery is very different for everyone, so it is important to have inclusion and multiple options for both the recovery process and end goals.

Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.

SAMHSA's Definition of Recovery

- **SAMHSA's Priorities and Guiding Principles** – Recovery is one of SAMHSA's four overarching principles. In addition, one of SAMHSA's priorities related to workforce has a significant focus on peer-related needs and issues.
- **Launch and Activities of SAMHSA's Office of Recovery** – The Office was launched in September 2022 and many of the staff have lived experience. The Office held a Recovery Summit in August 2022 and hopes to hold regional meetings like this across the ten SAMHSA regions.

2023 - 2026 | SAMHSA Strategic Plan



Participant Introductions

Participants had an opportunity to introduce themselves and share their connection to the field of recovery. Most participants had lived expertise and were very generous about sharing their personal journeys. In addition to substance use disorders (SUDs) and mental health conditions, participants shared experiences related to trauma and criminal justice involvement. Participants shared significant accomplishments and successes and noted how the field (recovery) has evolved over time.

I prefer the phrase lived expertise rather than lived experience because it conveys the invaluable contribution peers provide.

Keith Murphy

Participants were also given a short opportunity to connect with other participants in one-on-one conversations. A list of participants is provided in Appendix A.

State of Recovery in Region 5

Amy Brinkley, Recovery Support Systems Coordinator, National Association of State Mental Health Program Directors (NASMHPD)

In her role with NASMHPD, Ms. Brinkley works to ensure that the voices of those with lived expertise with mental health needs are promoted, heard, and considered in policy, planning and practice development. The state Office of Consumer Affairs began in the 1990s and now there are 44 states and territories with mental health recovery units in their state government.

In terms of resources, Ms. Brinkley shared the following:

- A [one-page factsheet](#) highlighting the benefits of investing in recovery.
- [A survey in 2021](#) which provides a better understanding of the recovery infrastructure and funding streams.
- A [workforce toolkit](#) developed to support states, particularly on issues related to the peer workforce.

Ms. Brinkley noted that NASMHPD will be releasing a publication in a few weeks about crisis services and how the increased demand has created a workforce shortage. Some of the salient points of the publication are:

- States report shortages across the crisis service spectrum (988 line; mobile teams; stabilization centers and residential facilities).
- Several states (45% of those interviewed) are working to increase Medicaid reimbursement rates for peer services. The rates across states vary widely (from ranging from \$7.83/15 minutes to \$24.27/15 minutes).

She noted that being involved in criminal justice systems still poses a barrier to peer employment. If these barriers are removed, they would considerably expand the pool of peers who could enter the workforce. SAMHSA's Serious Mental Illness (SMI) Advisor has developed [a toolkit](#) that covers three modules for employers ([pre-hiring, hiring, and post hiring](#)).

Background checks should be the responsibility of hiring organizations rather than part of the peer certification process.

SAMHSA National Model Standards for Peer Certification

In terms of future opportunities, Ms. Brinkley shared the following:

- **Peer Workforce Resource** – The National Council is launching a Center for Workforce Solutions which has a peer focus.
- **Certified Community Behavioral Health Centers (CCBHCs)** – Many CCBHCs are partnering with peer-led organizations to provide their peer support service needs rather than using an in-house approach.
- **Peer Respite** – These are increasing. A directory of respite is provided on the [National Empowerment Center website](#).
- **Peer-Run Step Up/Step-Down Programs and Peer Run Crisis Programs** – States are beginning to provide more peer-run initiatives. New Hampshire has a model Step-up/Step-Down program and New York's crisis program is peer-run.

Ms. Brinkley closed by sharing some highlights of activities for each of the Region V States. These are detailed in Appendix B.

State Representatives Reactions

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

Ohio

Jamie Carmichael, Assistant Director, Community Planning and Collaboration, Ohio Department of Mental Health & Addiction Services

Ohio has a Bureau of Recovery Support with about 20 staff. Their work includes addressing employment, housing, community transition and the peer workforce. Other key aspects she shared include:

- **Increased Investment** – There is more money for recovery housing and quality grants which reflects that policymakers are now better understanding the importance of recovery.
- **Assistance to Landlords** – Landlords can get funds to bring their properties to certification. The state is also working to minimize landlord risks so that they will provide housing for high-risk tenants (e.g., convicted of arson or trafficking).
- **Peer Credentialing and Training** – Credentialing has now been migrated to the same platform as other medical boards. The state is working with the Chemical Dependency Board to explore moving that credential under their licensing authority. In addition, Ohio is working with a university to provide continuing education units (CEUs). All of this is intended to better professionalize the peer role.
- **Crisis Rules Package** – Ohio is developing a new Crisis Services rule package. As part of that work, peers will be recognized as having a role in the Crisis Services continuum. In addition, Ohio's most recent operating budget adds Mental Health Peer Services as a billable Medicaid service.
- **Employment** – Ohio continues to work on growing access to Supported Employment programs, and benefits planning to allow people to work without unnecessary loss of critical benefits and services.

Michigan

Angie Smith-Butterwick, Substance Use, Gambling and Epidemiology Section Manager, Michigan Department of Health and Human Services

Key aspects shared by Ms. Smith-Butterwick were:

- **Behavioral Health Funding** – Michigan has a carve-out for behavioral health that is distributed across ten managed care organizations across the state. The Department of Health and Human Services ensures that services are equitable and that there are standards of care.
- **Recovery-Friendly Workplaces** – The state has a contractor to provide technical assistance to employers focused on addressing stigma and encouraging more hiring of individuals in recovery.
- **Retention Data/Living Wage Concerns** – This information is currently not collected. However, it is known that there is great variability in pay scales across agencies/employers.
- **Housing** – Michigan has used their State Opioid Response (SOR) grant and opioid settlement to fund recovery housing, to create more housing and to certify existing housing.

- **Project Assert** – The state has adopted Project Assert which provides Screening, Brief Intervention, and Referral to Treatment (SBIRT) screening in hospitals, Federally Qualified Health Centers or FQHCs, correctional facilities, and tribal locations.
- **Mobile Methadone Units** – Michigan has three mobile medication units.
- **Narcan Distribution Portal** – Any agency can now obtain Narcan free of charge.
- **Ethics Training** – Many peers have trauma and come from broken homes, so the training strives to help avoid pitfalls and make peers successful in their work.

Illinois

Nanette Larson, Deputy Director, Wellness & Recovery Services, Illinois Department of Human Services

Ms. Larson noted that the Division of Mental Health and the Division of Substance Abuse are separate but work closely together. Other key aspects she shared include:

- **Peer Certification** – Illinois certifies peers through the International Certification and Reciprocity Consortium (IC&RC) and the state has one of the strongest certification requirements in terms of training and experience. This is by design as they want peers to be identified as professionals and can bill Medicaid at the same rate as a clinical professional.
- **Continuing Education** – Illinois partners with 11 colleges/universities to provide continuing education trainings. The colleges/universities are also required to coordinate internship sites and provide appropriate wraparound support. These approaches have resulted in a 400% increase in the number of peers.
- **Recovery Community Organizations (RCOs)** – With SAMHSA grant funds, Illinois has been able to support 14 RCOs, one of which is a coalition of multiple sites. They hope to expand RCOs to have coverage for all 102 counties. The focus has been to provide integrated RCOs that provide support for both individuals with SUD and those with mental health disorders.
- **Reentry Project** – Illinois has funded a pilot reentry project which will provide pre- and post-incarceration support at the Decatur Correctional facility using peers.
- **Recovery Housing** – There are 98 recovery houses (e.g., Oxford houses, sober housing and others) which translates to nearly 2,000 beds. Most of the housing is funded by the State. There is a revolving fund to help set up new Oxford houses.
- **Overdose Prevention and Support Linkages** --- RCOs provide harm reduction including access to Narcan. The State provides Narcan free of charge to hospitals, clinics, and prisons/jails. The State also operates [MAR Now](#) which connects individuals with providers who can provide medication-assisted treatment (MAT).
- **Recovery Oriented Systems of Care (ROSC) Councils** – The state has 41 Councils covering 56 counties.

Minnesota

Darren Reed, Peer Recovery Services Coordinator, Behavioral Health Division, Minnesota Department of Human Services

Key aspects shared by Mr. Reed include:

- **Sober Living** – Minnesota will be conducting a survey to collect information on recovery homes including their funding source and special populations served.
- **Certified Peers Services** – Minnesota has peers for SUD and mental health, as well as family peers.
- **Providers** – Counties are now recognized providers of SUD services.
- **RCOs** – The number of RCOs is expanding and they are supporting overdose prevention needs. There is also more collaboration between RCOs and collegiate/high school recovery programs.

Wisconsin

- Kenya Bright (present virtually) represented the Wisconsin Department Health Services and added a few comments in the Zoom chat that Wisconsin has a peer specialist certification that integrates both substance use and mental health, 6 peer run respite centers, multiple drop-in peer recovery centers, and many other peer-to-peer support initiatives.

Discussion

As the moderator, Ms. Brink provided some guidance questions.

What are federal resources that have been helpful towards establishing recovery resources?

- Most of the recovery funds used in Ohio are traditionally state funds. Local Board also use state funds to support Recovery Supports. The use of SAMHSA block grant funds for Recovery Supports has not been maximized, and our director has asked the Department to focus on spending more block grant funds/dollars on Recovery. Ohio wants to expand recovery supports including peer services to include youth, families, and correctional peers.
- Michigan wants to expand peer services to include youth, families, and correctional peers.

In working with local stakeholders, what resources do local communities most value?

- Mentoring and coaching services that are done one-on-one with individuals. Connection matters.
- It is important for states to recognize the importance of the local voice (“flip the script”).
- One voice can’t represent everyone with lived expertise. That is why data and surveys are important as they can better capture the experiences. As an example, a survey revealed that African Americans in recovery were three times more likely to have housing needs.

What would a perfect system look like in your State?

- Early intervention services and on-demand access to treatment and recovery services.
- More pretreatment housing.
- A variety of options to meet individual needs. Some programs like 12-steps work great for some people but not others (e.g., not abstinent, or non-faith-based options). Conversely, traditional programs may reject RCOs if there are not introductions made first and they are deemed too radical.
- Recovery coordinators. There are seven regional prevention coordinators in Minnesota. There should be recovery counterparts that work to create more awareness and funding for this work.

It hurts to see a person who wants treatment but can't get a bed.

Darren Reed

- More options for rural communities.
- More collegiate recovery as well as connections of these programs with community RCOs.

Participants then had an opportunity to provide comments.

- **Systems Have Caused Harm and Aren't Sharing Power –** Systems need to share power and do so with humility. It is difficult to share pain and to be reflective during periods of turmoil.
- **Much of Addiction is Poverty-Driven –** There needs to be more focus on addressing basic needs. Admittedly, this involves working with multiple agencies.
- **Not Forcing Beliefs –** Many drug courts mandate faith-based programs.
- **Equity –** Ohio focuses on health opportunity zones (based on the Centers for Disease Control and Prevention's vulnerability index) to prioritize needs, which often are in communities of color. It is also important to remember that the response to the crack epidemic has caused harm to African Americans with residual repercussions today.
- **Grassroots Focus –** Individuals should be asked directly what is needed to be healthy. Ohio leverages trusted Community Based Organizations to run “coffee on the corner” listening sessions or postings at the Dollar General to get a better pulse on community needs.
- **Working with Law Enforcement/Judges –** These professionals want to hear from their peers (e.g., other judges), so having champions helps to better engage these stakeholders.
- **Recovery Community Organization (RCO) Capacity –** RCOs need more funds and support to help address the administrative needs to build capacity.
- **Co-opting of Peers and Harm Reduction –** Rather than a true engagement, large systems have approached RCOs for information but do not include them further in the leadership or implementation. RCOs are more reflective of the community and rather than being empowered, they are instead often exploited by larger institutions.
- **Funding –** Recovery system-wide is not financially supported and valued. Treatment providers see RCOs as competition and can sometimes even be hostile, rather than seeing RCOs as complementary allies.
- **Standards –** Peers need to be used with fidelity (e.g., not as a junior counselor). Their role is to help individuals to build their recovery capital.
- **Never Enough Beds –** There will never be enough beds and evidence-based practices show that outpatient programs are highly effective. This makes the peer role which supports community-based recovery so important.

I want to challenge the idea that compassion is enough for recovery. Individuals need to have their basic needs met.

Patti Heffernan

Breakout Session

Participants then met in breakout sessions focused on Diversity, Equity, Inclusion and Accessibility (DEIA), and the Social Determinants of Recovery (also referred to as Social Determinants of Health). They were asked to discuss the following:

- What is going well in your local community, regionally and nationally?

- Where do we (the Mental Health and Substance Use Disorder 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.

Minnesota

What is going well?

- More collaboration.
- A stronger, more enthusiastic, and diverse community working in recovery.
- Treatment access in schools through State funding.
- Inclusion of youth as peers.
- Variety of functions from RCOs to recovery high schools.
- Mental health peers are growing, though more are needed.

Where to focus on to make positive progress?

- Need to have more conversations about recovery.
- More youth services (e.g., starting at adolescence).
- More tertiary and mental health prevention. We shouldn't wait for someone to get sick.
- Treatment access.
- The system is difficult to navigate.
- Barriers with background studies.
- Families need to be educated about addiction and recovery.
- Policy barriers, albeit unintentional.
- More access to Medications for Opioid Use Disorder (MOUD)
- Workforce shortages don't allow for expansion.
- More education in rural areas.

What do you wish the end goal to look like?

- RCOs are fully funded and serve youth and families.
- Social/fun activities type services.
- No stigma.
- Recovery includes health, home, purpose, and community,
- Inclusive in language and practice. "Recovery for all."

Recovery should include a safe place to live, meaningful work, and a date on Saturday night.

Minnesota team operationalizing recovery goals

Illinois, Indiana, and Wisconsin

What is going well?

- Resource rich. (Wisconsin)
- More accepting of harm reduction approaches. (Illinois)
- More discussion about mental health due to the pandemic. (nationally)

- Increased peer certifications and supportive, listening decisionmakers. (Illinois)
- More money available. (Illinois)
- More local support for recovery services. (Wisconsin)

Where to focus on to make positive progress?

- Address systemic racism.
- Openness in understanding the goals of recovery and the importance of lived expertise.
- Address tokenization.
- Decentralize power back to impacted communities and peers. (Wisconsin)
- Have other funding besides Medicaid.
- Mental health peer organizations get funded the same as RCOs. (Illinois)
- Better protection of peer organizations from being co-opted.
- Options to be a peer outside of certification.

What do you wish the end goal to look like?

- Being more culturally relevant in terms of skills and training.
- Peers being more valued and recognizing their expertise beyond merely certification.
- Supervision of peers by peers.
- Language that invites inclusiveness (e.g., not requiring abstinence) and is universally understood.
- Adopting communication and collaboration approaches that are used in marginalized communities. For example, less-hierarchical organization structures.
- Those with lived expertise should form the research questions.
- Peers have a voice in advocacy.
- Stronger collective vision of what peer support is. There are a lot of varying opinions.
- Greater focus on Social Determinants of Health (SDoH) needs.
- There may be drawbacks to having peers everywhere. Define goals and determine who is needed in different spaces.

It is hard to move a workforce forward when everyone interprets definitions differently.

Illinois, Indiana, and Wisconsin Breakout group

Michigan and Ohio

What is going well?

- Increased awareness of Diversity, Equity & Inclusion (DEI), though it does need to expand and address the compounding of problems related to the intersectionality of identity.
- An influx of money and new tools and information to improve practices.
- Better data collection and analytics that help to identify disparities and where best to direct resources.
- An openness to review and update policies.
- An increased support for population-based services.
- More attention towards building recovery capital and addressing SDoH.

Where to focus on to make positive progress?

- Expand the capacity for grassroots organizations. There is a lot of gatekeeping and needs (e.g., a grant writer or clinician) that precludes getting funding. This is an issue with the grantor (e.g., SAMHSA and others).
- More flexibility in the block grant. The field are experts and should decide how to spend resources.
- Simplify reporting and data collection. We would like to get rid of the Government Performance and Results Act assessment (GPRA).
- Embody harm reduction not just as a service but a culture where everyone is afforded respect, honor, and dignity.
- Treat the whole family.
- Decriminalize behavioral health. It's an illness.
- Improved system alignment. Prevention, treatment, and recovery are pitted against each other so that they work in opposition of each other for funding and service delivery resources.
- Provide holistic programs that also address economic and environmental factors.
- Let programs drive where funding should go rather than vice versa.
- Support robust data collection analysis and research. There are legislative data platforms that are decades old and need to be updated.
- Support innovation efforts (e.g., startup funds for an incubator program). Evidence-based practice requirements can be a barrier to good work. Ohio has a pilot program to fund grassroots organizations without fiscal and administrative expertise.
- Research should be longitudinal and connect medical, social and recovery experiences together.
- Support locally driven programs in a sustainable way.
- Align public and private funding so that they are not duplicative and address funding gaps.

If someone has a physical chronic disease, they are supported for the rest of their life. Treating behavioral health using an acute-care model is a parity issue.

Ahmed Hosni (paraphrase)

Zoom 1

What is going well?

- More inclusion of peers and a new statute supporting harm reduction. (Wisconsin)
- More enthusiasm for peers and move the peer certification to a platform (e-license) that can be universally accessed. (Ohio)
- Expanded RCOs, Faces and Voices in Recovery funding and a Bringing Recovery Supports to Scale Technical Assistance Center SAMHSA grant. (Michigan)
- Opened a peer program in prisons. (Michigan)
- Provides for tracking of peers through its continuing education (CE) requirement. (Michigan)
- Opened the state's first peer respite. (Michigan)

- Increased the focus on DEI and harm reduction. (Wisconsin)
- More focus on using peers effectively (not just as assistant case managers). (Wisconsin)
- More DEI work and legislative funding for rural and frontier communities. (Minnesota)
- More attention on peer support and crisis alternatives. (national)
- More emerging youth leaders and advocates. (national)

Where to focus on to make positive progress?

- Offer those in recovery equal opportunities, safe spaces, and activities to do with their time.
- Build a culture that provides feedback loops and is healthy.
- Provide adequate benefits for peers. The medical model does not work for peer support.
- Co-create and dream big.
- Expand DEI lens. Include youth, families, the deaf and hard of hearing, etc.
- Expand certification (e.g., family). Wisconsin used a focus group to identify those gaps. The State has also started a family resource center.

What do you wish the end goal to look like?

- Peer support for prevention before a crisis.
- Use data to target resources.
- Be open-minded and flexible in services.
- Allow more focus on work rather than administrative requirements.
- Don't use ideas that don't work.
- Transparency.
- Better educated legislators.
- Have peers run respites, warmlines, and virtual support help.
- Use law enforcement as deflection.
- Address SDoH.

Zoom 2

What is going well?

- Recovery programs are a staple and used at all levels. (Detroit)
- At the forefront of providing peers across the level of care. (Michigan)
- An increased value towards peer services and convening focus groups to better understand people in recovery. (Decatur)
- An open mindedness to try new things. This includes building peer support in other areas (e.g., domestic violence and homeless shelters). (Appleton)
- Crisis intervention training for police and new partnerships with law enforcement.
- Peers working with probation and parole as well as specialty courts. (Detroit)
- Support for reintegration of returning citizens.
- Legislators have toured a respite. (Madison)
- Peers are within the crisis network. (Madison)
- Police are trained in trauma-informed care. (Madison)

- Expanded peer respites including the nation's first veteran-specific peer respite. (Wisconsin)
- Increased awareness of peers which has, in turn, reduced stigma. (Michigan)
- A greater level of understanding about the importance of recovery. (national)

Where to focus on to make positive progress?

- A greater focus on peer leadership and a career ladder.
- Explore State-to-State reciprocity (e.g., standardize certification).
- Fund through both Medicaid and private sources.
- Remove barriers that make it difficult to call mobile crisis services, forcing individuals to use the police or an emergency room.
- The peer certification doesn't seem to be professional enough (there is no sign-off).
- Address burnout and high student loans (e.g., for social workers).
- Agencies/hospitals respect peers more and understand how to best use them. Emergency Department staff, for example, often don't understand the value of peers.
- Specialty courts should approach relapse by looking at the challenges and providing support rather than only providing incarceration as an option.
- Medicare doesn't fund residential impatient unit.

What do you wish the end goal to look like?

- More parity. Offer yearly check-ups, like with physical health.
- Road to treatment is less complicated.
- More housing and employment options.
- Health navigators.
- More policymakers with lived expertise.
- Individuals with lived expertise are consulted in how opioid money is spent.
- Trainings for employers.

When I got my cancer diagnosis, I got a nurse health navigator within hours of my diagnosis. I didn't get that with my mental health diagnosis.

Paula Verrett

Final Thoughts

Participants then had an opportunity for open discussion on issues that resonated with them.

- **Legal Credential** – Another credential to consider would be a legal credential which would relate to any involvement across the [sequential intercept map](#).
- **Youth** – There needs to be more focus on youth because there is a lot of benefit from changing a person's trajectory as early as possible. Ms. Zeller noted that many grant makers do target youth programs.
- **Prenatal Intercept** – Particularly in poor and marginalized communities, there needs to be more support to moms. Prenatal and family services are important to break intergenerational behavioral health issues.

- **Parents Impact on Children** – When parents go to therapy, there are better outcomes. Society still dehumanizes and criminalizes parents with behavioral health needs.
- **System Harms** – The systems have harmed many historically marginalized communities. That is why there is a need to center these voices to rebuild trust and transform the systems to provide better and equitable services.
- **Black Indigenous People of Color** – People of color are still treated poorly in clinical settings. They are not being listened to nor do they have their family support included in their care. And they have more unmet SDoH needs.

Mr. Murphy closed out Day One noting that participants have a lens and a mirror. The lens is how a person sees the world and who is intentionally pulled into your life. The mirror is the community developed that reflects this lens.

It is easy to love children who are in the system. But we need to care more for their parents' needs. We separate children far too much from their families.

Pam Heffernan (paraphrase)

If we focused more on SDOH needs, we would have a greater impact. Kids need their families. They are not like candy with the parents being wrappers that can just be thrown away.

Jamie Carmichael (paraphrase)

DAY TWO

As a start to Day Two, Mr. Murphy asked participants to share their takeaways from Day One. Participant shared the following:

- **Ms. Carmichael** noted that she found this to be a different kind of meeting which was grounded in humility. She chose the word “learn” yesterday but has since changed that to “operation” because she wants to hear more about “how” other states are implementing these programs.
- **Mr. Tomsha** also noted that he wanted to learn the “how” of getting a program started. He has already reached out to one of SAMHSA’s Addiction Technology Transfer Centers for support. He also appreciated seeing inclusion of multiple pathways which included non-abstinent recovery.
- **Mr. Hosni** chose the word “listen.” He usually is in meetings where he does a lot of talking but there has been a lot to learn here. He appreciated the diversity of support services and how the field has grown exponentially.
- **Mr. Harper** appreciated seeing community, state and federal participants coming together and dissecting programs from micro to macro and vice versa.
- **Ms. Larson** has been in the field for a long time, recalling when the field was first just trying to define the term recovery. With this long-term lens, she has been able to see a significant change in the conversations. Over 20 years ago, mental health recovery was not welcome in the conversation. Today, it still needs to be elevated – as does youth recovery services – but she acknowledged that the perspective is much more welcomed. She also noted that

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

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

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

Ms. Heffernan

Recovery Services in Various Settings

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

AJ French

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

Mike Durchslag

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

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

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

Tim Saubers

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

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

Brandon George

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

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

Ahmed Hosni

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

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

Mr. Hosni

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

Pam Werner

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

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

Discussion

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

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

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

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

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

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

Mr. George

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

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

Ms. French (paraphrase)

Audience Questions

The following are questions/comments from audience participants:

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

It is a mistake to medicalize peer services.

Ms. White

Breakout Session

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

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

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

Following are the report outs from each of the groups.

Zoom 1

Where to focus on to make positive progress?

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

What are the top three areas that need attention?

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

Zoom 2

Where to focus on to make positive progress?

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

Smoking cessation and nutrition are particular wellness programs needed for people in recovery.

Breakout (paraphrase)

What do you wish the end goal to look like?

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

We want individuals to have the right resources for when they need it. Like bank ATMs where an individual can get access to their money anywhere.

Breakout Participant (paraphrase)

Illinois and Wisconsin

What is going well?

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

Where to focus on to make positive progress?

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

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

Nanette Larson

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

What do you wish the end goal to look like?

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

Apply radical empathy eliminating “othering” people. This includes not just individuals but also State and clinical staff who may not understand our perspective.

Illinois/Wisconsin group
(paraphrase)

Michigan and Ohio

What is going well?

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

What do you wish the end goal to look like?

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

Recovery is complex. Innovation rather than cookie cutter approaches is needed. These illnesses pivot so recovery services should be allowed to do so also.

Michigan/Ohio group (paraphrase)

Minnesota

What is going well?

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

Where to focus to make positive progress?

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

What do you wish the end goal to look like?

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

Prioritization Activity

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

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

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

Lived experience should have respect regardless of the individual's professional background.

Kristen Harper group (paraphrase)

Lived expertise is something I have. Peer support is a job skill set.

Nze Okoronta

Wrap up and Next Steps

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

About the Realizing Recovery Series

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

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

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

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

Appendix A: Participant List

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Appendix B: Region V Peer-Related Activities

State	Activities
Illinois	<ul style="list-style-type: none"> • Increased funding for employees and retention payments/grants for providers. • Academic Center of Excellence partnership / funded a ‘behavioral health care education workforce center’ to assist with crisis workforce shortage. • Certified Recovery Support Specialist Program – course work, internship, and behavioral health workforce placement in partnership with universities. • Career pathways for Peers in Medicaid create equality for peer professionals related to pay/supervision capabilities.
Indiana	<ul style="list-style-type: none"> • Current efforts to standardize and professionalize the peer state certification. • Intense focus on recovery data collection. • Recovery Research project underway currently. • Legislation mandating peers on mobile crisis teams.
Michigan	<ul style="list-style-type: none"> • Parent Support Partners imbedded into children’s behavioral health system. • Increased peer support specialists in forensic/clinical settings. • They intend to incorporate incentives to address the social determinants of health. • Currently 13 CMHCs that are CCBHCs, and they were told that if they are either an existing CCBHC or a CMHC that would like to expand into being a CCBHC that they could apply. • MI’s community mental health organizations are obligated to provide crisis intervention regardless of if an individual identifies as being severely mentally ill or in the moderate or mild category.
Minnesota	<ul style="list-style-type: none"> • TTI Grant 2023 - Building Crisis Services that Serve Under-Resourced Minority Communities. • They plan to standardize certification of peers – connected with Texas in 2023. • There is some hesitation from providers to incorporate peers into their crisis service systems due to challenges with workforce recruitment in general.
Ohio	<ul style="list-style-type: none"> • Loan repayment and tuition reimbursement for treatment sector with goals to expand into recovery sector. • Ohio investing in statewide Peer recovery organization model to support state infrastructure. • State-wide recovery summit coming up – lots of national representation. • Recent collaboration with state of Indiana/ • Specialized peer track to include Latin-x and LGBTQ+ /

- | | |
|--|---|
| | <ul style="list-style-type: none">• Initiatives to hire peer specialists who are deaf or hard of hearing. |
|--|---|