

# **Peer Possibilities: National Peer Workforce Summit**

## **Executive Summary and Meeting Report**

Hyatt Regency Reston, Reston Virginia

**August 23-24, 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 report was developed by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Office of Recovery, with contributions from Jessi Davis and Dana Fogleson (National Association of Peer Supporters). The content of this report was reviewed, and all themes within were identified or expressed by technical experts/those with lived experience (see "Appendix A" for a full list of participants) during the National Peer Workforce Summit.*

*Please note that the views, opinions, and content expressed within do not necessarily reflect the views, opinions, or policies of the Office of Recovery (OR), 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 to advancing the field of recovery.**

## Table of Contents

EXECUTIVE SUMMARY .....	4
Common Themes .....	4
Solutions and Thoughts Moving Forward .....	5
MEETING REPORT .....	7
Welcome .....	7
Overview of SAMHSA’s Office of Recovery .....	7
Speed Introductions .....	9
Keynote: The Power of Hope .....	9
Authenticity Panel.....	9
Breakout Sessions .....	12
Peer Financing Panel.....	12
Day Two Welcome .....	16
Federal Representatives Panel .....	17
Breakout Sessions .....	18
Peer to Career Panel.....	18
Final Thoughts: Identify a Priority.....	21
Appendix A – Participants List.....	23
Appendix B – Breakout Session Reports.....	29

## EXECUTIVE SUMMARY

The SAMHSA Office of Recovery has a vital role in advancing recovery across the nation. 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 23-24, 2023, the Office of Recovery hosted the *Peer Possibilities: National Peer Workforce Summit*. The gathering brought together over 100 individuals representing persons with lived experience of mental health or substance and staff of federal and state partners.

*The purpose of this Summit was for SAMHSA to solicit feedback from stakeholders to better understand the variables that impact the expansion of the peer workforce, as well as identify gaps and scalable solutions to increase peer support across the country.*

Over the two days, speakers and panelists provided perspectives on authenticity; financing of peers; and peer career considerations. There was also a panel with Federal stakeholders where representatives from National Institute on Drug Abuse (NIDA), the Centers for Medicare and Medicaid Services (CMS), Department of Veterans Affairs (VA), SAMHSA's Office of Recovery, and the Health Resources & Services Administration (HRSA), discussed peer workforce issues. Several themes emerged over the course of the two-day convening along with suggested follow up items for SAMHSA's Office of Recovery to consider in future peer workforce initiatives.

### Common Themes

Following are common themes identified during meeting discussions.

- **Defining the Term 'Peer'** - SAMHSA's Core Competencies for Peer Workers in Behavioral Health Services describes peer support as "offering and receiving help, based on shared understanding, respect and mutual empowerment between people in similar situations." The terms 'peer supporter', 'peer worker', and 'peer specialist' are interchangeably used to describe a person (including family, friends, and loved ones) with lived/living\* experience involving problematic mental health and/or substance use conditions, and who engages in a wide range of activities, including advocacy, linkage to resources, sharing of experience, social support, community and relationship building, group facilitation, skill building, mentoring, goal setting, and more. Across the United States, various other terms such as recovery coach, mentor, peer provider, or peer navigator are used to describe peer workers. In the context of the peer summit meeting, the term 'peer worker' was used to generally describe someone working in a peer support role (both certified & non-certified, unless specifically noted).
- **History Matters** – Participants recommended reclaiming their history which includes strong examples of peer empowerment and advocacy.
- **The Peer Community is Not Homogeneous** – Participants appreciated the Office of Recovery convening diverse aspects of the peer community together and providing a space for uncomfortable discussions. But there is more work to be done to be fully inclusive of

members of the disability community; Black and African Americans; those who practice harm reduction and non-abstinent approaches; and family/parent peers.

- **Federal Partners Need More Peer Input**– Federal partners are often not fully engaging people with lived experience in their efforts. While it was acknowledged that some Federal restrictions are statutory, engagement between peers and Federal partners helps with education; reducing stigma; and, most importantly, ensuring that the policies and financing are relevant to peer services.
- **Clinical Systems Need to be Recovery-Friendly** – There were many concerns related to the well-being of peer support staff within clinical settings. These ranged from not understanding what peers do (e.g., supervision); to more serious allegations of co-opting peer services and creating toxic environments with burnout, tokenism, stigma, and disrespect. Further, peers, when placed in clinical settings, can be pushed into a medical model approach, and asked to do things not within their scope of work like run therapy group sessions) or do clerical or administrative tasks.
- **The Peer Role is Valuable and Should be Protected** –To bolster the peer workforce, it is essential to fortify peer-run agencies. This involves enhancing their capacity and infrastructure, while concurrently cultivating leadership skills to thrive in the healthcare landscape where they can make a significant impact. Defining the peer role and values are a prerequisite for the community to grow. There was creative tension between whether peer workforce should be an identity, a role, or a relationship. Too broad a definition will water down the value. Too narrow will exclude valued members of the peer community (e.g., harm reductionists).
- **Financing Barriers Limit Peer Efforts**– Again there is tension in having sustainable funding but having to accept the administrative requirements. For example, fee for service approaches may employ “medical necessity determinations” and 15-minute billing increments. Funders also tend to not finance important infrastructure and Social Determinant of Health (SDoH) needs. And braiding services along with some reporting create administrative burdens taking peer leaders away from doing more direct service delivery and staff support. Flexibility was also mentioned noting that there is not a single pathway to recovery so all options, including culturally relevant practices, need to be covered.
- **Peer Career Issues are a Symptom**– Low pay, burnout, lack of workforce are symptoms of an unhealthy system. Peer burnout and well-being cannot be rectified without addressing the systemic environment in which they operate.

## Solutions and Thoughts Moving Forward

Following are some solutions and thoughts that may guide the Office of Recovery, SAMHSA, and the peer community.

- **Broker More Conversations** – SAMHSA is well-poised to broker efforts to get peers involved with other Federal partners (e.g., CMS, Department of Labor, etc.). In addition, the Office of Recovery should

*An overarching theme for solutions moving forward focuses on ways that peers can change the system from within.*

continue to provide space for internal peer community discussions to resolve issues and develop a sense of community.

- **The Important Role of Community Based Organizations (CBOs)/Recovery Community Organizations (RCOs)** – These are peer-led organizations and can serve the role of supporting peers (e.g., like unions) and ensure authenticity. It was noted that a model of “infusing” peers through peer organizations rather than integrating them as employees in larger systems would be more effective and improve the well-being of the peer workforce. However, peer organizations need to have a strong infrastructure, and funding is rarely available for that need.
- **Elevate Equity Concerns** – While there are admittedly significant external equity concerns, SAMHSA can help address equity concerns across different members within the peer community.
- **Provide Better Understanding of Federal Assets and Barriers** – A participant noted that there was a lot of jargon expressed that grassroots peers were not familiar with. In addition, some Federal participants explained reasons why certain policies are made (e.g., statutory requirements). Bringing in the peer community to work on these issues helps with that education but also allows the community to identify advocacy needs and creative ways to address these barriers.
- **Address the Peer Role Drift** – Now that the SAMHSA’s National Model Standards for Peer Specialist Certification have been issued, the Office of Recovery might focus on the definition of peers; the threats to the role of a peer (which may even include certification); clear job definitions; and a set of common values that can unify the community.
- **Provide Clarity on the Intersection of Recovery and Harm Reduction Services and Approaches** – Where does harm reduction begin and end within a recovery context? Vice versa, where does recovery begin and end when applying a harm reduction lens? There is a lot of support from both harm reductionists and recovery advocates to coordinate services that are complimentary of each other. The goal is saving lives and assisting individuals with their health and wellness goals; however the individual defines them. The tools that service providers use to accomplish this though, need further clarification for efficacy purposes.

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## DAY ONE

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### MEETING REPORT

#### Welcome

Kristen Harper with SAMHSA's Office of Recovery gave an overview of the agenda and goals of the meeting. She also shared that she initiated her own personal journey of recovery at 19 years old. She acknowledged the roles of peers in this journey and thanked the meeting participants for the work they do daily.

Sonia Chessen, SAMHSA's Chief of Staff also welcomed participants on behalf of the Assistant Secretary for Mental Health and Substance Use, Dr. Miriam Delphin Rittmon, and Acting Principal Deputy Assistant Secretary, Mr. Tom Coderre. She noted that the Biden Administration has elevated the role of peers, both in providing recovery support as well as addressing the opioid overdose epidemic. Regarding SAMHSA, the agency has been engaged in the following peer support activities:

- Launching the Office of Recovery
- Incorporating recovery as one of SAMHSA's strategic plan guiding principles
- Collaborating with other Federal partners (e.g., the Centers for Medicare and Medicaid Services (CMS), the Health Resources and Services Administration (HRSA) and the Department of Veterans Affairs) to build up the peer workforce and provide sustainable funding streams.

*Peers demonstrate the power of recovery every day.*

Sonia Chessen

Keris Myrick, Vice President of Partnerships at Inseparable served as the Day One facilitator.

#### Overview of SAMHSA's Office of Recovery

*Paolo del Vecchio, Director, Office of Recovery*

Mr. del Vecchio revealed that he is a person in long-term recovery (e.g., 38 years) and that there are over 50 million Americans who also identify as being in recovery. He encouraged the participants to lean boldly into discussions on the struggles and challenges with expanding the peer workforce. Potential topics for consideration include the following:

- Authenticity
- Financing
- Career advancement and pay scales
- Supervision and peer drift
- Diversity, equity, and inclusion

*There will be a lot of work to do in this Summit. But also, a lot of promise and possibilities.*

Paolo del Vecchio

## Office of Recovery

Mr. del Vecchio then gave an overview of the Office of Recovery. He noted that while the Office is not quite a year old, it grew out from a long history of recovery advocacy. In 2022, SAMSHA convened a Summit and out of that event and there was a clear direction from attendees to adopt a “big tent” approach to recovery. This means focusing on people in recovery from substance use and mental health conditions, family members, and those who are in recovery but not abstinent. And accepting multiple pathways to recovery.

Since the Office’s launch, they have been engaged in the following efforts:

- Development of a [National Model Standards for Peer Support Certification](#);
- Regional meetings; and
- Technical expert panels on a variety of topics including warmlines, criminal justice involvement, and housing.

He then highlighted some of the Office’s works across SAMHSA’s five recovery goals:

- **Inclusion** – Most of the Office staff are themselves in recovery as SAMHSA has issued a formal policy on inclusion to be a ‘model employer’ for individuals in recovery.
- **Equity** – The Office has advanced understanding and support for underserved communities. Several weeks ago, the Office convened a 300-person tribal summit on recovery which focused on historical trauma and healing practices. They are also developing a compendium that will include practice-based evidence.
- **Peer Services** – Today’s meeting is part of this effort which is focused on raising the quality and authenticity of peers. The National Model Standards also focused on peer services and SAMHSA just released a guidebook on hiring individuals who have been involved in the criminal justice system. There is also work to strengthen recovery-based organizations and high-school/collegiate recovery programs.
- **Social Determinants of Health** – SAMHSA has held meetings on housing and employment issues and worked with partners like the Office of National Drug Control Policy to provide technical assistance and guidance.
- **Wellness** – Mr. del Vecchio noted that individuals with substance use disorder (SUD) and mental health conditions, even when in recovery, die far too young from other comorbidities. There are also issues related to restraint during crisis. Advocacy is needed on these fronts.

Mr. del Vecchio noted that baked-in to all these efforts are the core principles of data and evidence, trauma responsiveness, and rights protection.

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)



- A Release of data on mobile recovery (September 20)
- A Day of Service (September 30)

## Speed Introductions

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

## Keynote: The Power of Hope

*Kathryn Goetzke, M.B.A., The Shine Hope Company*

Ms. Goetzke has been in recovery for 19 years and shared her journey in the field of “Hope Science.” She shared that she founded an organization called Mood Factory. She learned that a consistent predictor of behavioral health struggles is hopelessness. She noted that hopelessness has an emotional component (despair) and a motivational component (helplessness).

*Hope is a strategy, not just a wish.*

Kathryn Goetzke

These experiences became a catalyst for her in researching the science of “Hope,” and specifically how to measure it and redirect outcomes for this protective factor. She founded the Shine Hope Company which developed both an [adult](#) and [children’s](#) Hope Scale.

## Authenticity Panel

Through a series of guided questions from Ms. Myrick, panelists responded to the overarching question “what is an authentic peer experience”.

*Please share a brief introduction and how it relates to authenticity.*

### Kevin Rumley

Mr. Rumley is the Executive Director for a Veterans Treatment Court in North Carolina. He is a Marine Corp veteran who was injured and witnessed his best friend killed in combat. During his recovery from his wounds, he was placed on morphine and that led to an opioid use disorder (OUD). He suffers from PTSD and depression. He has been on medication assisted treatment (MOUD) for the past 12 years.

### Daryl McGraw

Mr. McGraw is the Director of Formerly, Inc. a reentry consulting service. He has been incarcerated, tased, choked and has an SUD. He noted that the turning point in his life was a 40-day spiritual motivation guide that he read in jail while waiting for his court date. He was sentenced to four years but used that time for his recovery journey and to help others. He now often works with the public defender’s office and highlights systemic racism within the system.

### Sue Smith

Dr. Smith is the CEO of the Georgia Parent Support Network. She shared a personal story of her family “adopting” a young waitress and her daughter. She noted that this encounter was a blessing

which didn't just change the trajectory of the waitress but also Dr. Smith's family. As an example, her husband had an alcohol use disorder and he ended up being in recovery.

### Jessi Davis

Jessi Davis is the President of the National Association of Peer Supporters as well as a Senior Administrative Program Coordinator with SAMHSA's South and Southwest Mental Health Training and Technical Assistance Center. Jessi noted that peer support programming impacted her life when she was under the age of 18 and she wants all young people to have access to quality Peer Support. Jessi created a training program to teach Peer Specialists how to work with young people.

### Wayne Cortez

Mr. Cortez is a peer recovery support specialist at Riverside-San Bernadino County Indian Health in California. He spent over 22 years incarcerated. He noted the value of tribal healing traditions and works to engage youth in these practices for prevention and intervention needs. He noted that American Indians have been particularly hard hit by behavioral health issues.

*What are some of the nuances that SAMHSA should understand regarding peer support?*

### Jessi Davis

Our field has challenges because of the "plain language" wording that we have added additional meaning to (i.e., Peer Support from a Peer Specialist is not the same as "peer support" in the plain language form). There are also many ways of offering Peer Specialist services. For example, just with youth, there is school-based peer support, alternative peer groups, special services for first episode psychosis. Age differences matter even with young people (e.g., a 13-year old's needs differ from a 16 year old), but that doesn't mean that Peer Specialists who are not near in age should be barred from working with a young person. Near-Aged Peer Support should always be recognized as the best practice regarding working with young people.

### Wayne Cortez

Culture, particularly for marginalized communities, are important for recovery. The Native American community has deep intergenerational trauma and these approaches (e.g., sweat lodges, Bird Dancing) helps in making individuals feel connected and have a sense of belonging. Some of the programs also have an intergenerational component with elders and youth connecting. It is important to note that each tribal culture is different.

### Sue Smith

Ms. Smith shared the story of an employee (Natalie) who had lived in a shelter. She had immense passion for her work as a peer and did a lot of home visits. When the Family Network did a survey to measure their outcomes, Natalie was consistently rated high by families as a resource.

Natalie faced stigma from staff (e.g., accusations of not doing her job) but she consistently went out of her way to help. Many peers have that passion within them, are willing to remain in the role, despite putting up with a lot of workplace issues.

### Kevin Rumley

Soldiers while enlisted have a strong sense of purpose and community. When they return to civilian life it can feel like being removed from their tribe. The Veteran's court is a 2-year diversion court, and everyone is matched with a veteran peer. Peers who have been the most successful are the ones that honor the dignity of the other person. Healing is often found within relationships.

*Veterans are willing to die for their country, but they sometimes are not sure how to live for it.*

Kevin Rumley

### Daryl McGraw

Mr. McGraw advocated that the term peer be replaced with PIR (Person in Recovery) as it honors the person's experience rather than the credential.

He noted that the organizations with the most authentic PIRs often do not have grant writers and as a result the right people are not getting the money to do their work.

Regarding individuals who are justice-involved, they need support starting at the beginning of their sentence not 30 days before release. Their families also need support. And many will need support for basic needs like housing.

*What does authentic peer support mean to you?*

- With families it is complicated because each has different needs, so whose goal is right and who do you listen to? Also, with transitional youth, there is the issue of when a child is old enough to make their own decisions.
- It means having lived experience but also listening to the individual's needs (e.g., not projecting your beliefs of recovery onto them).
- The individual gets to decide the definition of veteran. Some females won't reveal that identity and conversely there are some instances where someone doesn't fit that definition (e.g., 2 years enlistment.)

*Show your true self and nothing but. Youth know when you aren't being authentic. And sometimes wear jeans.*

Jessi Davis

### Discussion

Participants then had an opportunity to provide questions and comments.

- **Balancing Expansion and Authenticity** – The effort to expand the workforce to meet the demand could undermine authenticity.
- **Consistency in Identity** – We should not feel we need to “code-switch”. Your identity as a peer is the same identity when you present in a board room.

- **Peer Supervision** – What is the impact on peers in working within systems where the culture may be clinically-focused. Several panelists responded:
  - Peers should be supervised by other peers to prevent peer drift.
  - Some peers are pressured to do policing (e.g., doing urinalysis) for those that are trying to engage and build trust with. Peers should not be doing urinalysis.
- **Peer Exploitation** – One participant noted the low pay and that after a grant ended, was asked to volunteer his services.
- **Funder Demands** – A participant shared funders will impose their demands and even set unreasonable expectations (e.g., time limits for results). There is a need to educate funders that peers deal with human beings not widgets.
- **Abstinence** – While there is appreciation for the inclusion of individuals in recovery who are not abstinent, this belief isn't put into practice. This creates stigma and alienates segments of the peer community. Another person added that living experience has value just like lived experience.
- **Tokenism** – While tokenism isn't an ideal outcome, it is unfortunately a step in the process of getting in the door. Those that get in the door should hold it open for others. And if you are a token, don't assimilate.
- **Paternalism Towards Individuals with Disabilities** – While self-directed recovery is universally accepted, there may be paternalism for individuals with more stigmatized disabilities. There should be ASL interpreters always be available to the deaf and hard of hearing to ensure that they can fully participate in the process of their own recovery, and other accessibility accommodations must be discussed and provided throughout the entirety of the person's interactions with systems and peer specialists.
- **Language Matters** This can reduce peer drift (stay focused on the role) and co-opting of the role by systems.

## Breakout Sessions

Breakout sessions were convened to discuss the following subtopics:

- **Authenticity** – diversity of workforce, supervision and training, distinction of peerhood in integrated settings, advocacy and education of policy makers, peer employers and payers
- **Financing** – pay scale, cost effectiveness measures, diversifying funding streams to support peers (Medicaid, private payers, grants, etc.)
- **Peer to Career** – pay scale, certification, barriers to certification and or employment, reciprocity issues, career ladders, mentorship, networking

Written notes from these sessions are in Appendix B.

## Peer Financing Panel

Through a series of guided questions from Ms. Myrick, panelists responded to the issue of how to support peer financing.

*Please share a brief introduction and how it relates to peer financing.*

Lauren Foster

Ms. Foster is the Behavioral Health Program Manager at BlueCross of Minnesota. She noted that BlueCross has a new benefit that covers peer support.

Dana Foglesong

Ms. Foglesong is the National Senior Director for Recovery and Resiliency Services at Magellan Health. She also is the immediate past president of the National Association of Peer Supporters. She noted that peer services changed her life and wants to ensure that peer services follow peer support values and competencies. She has previous work in state government where she supported block grant funded peer services and started a statewide peer support program. For the past seven years, she has been in managed care where she leads peer support teams and programs.

Greg Williams

Mr. Williams is the President of Third Horizon Strategies which does advocacy. He said that storytelling is needed to explain to third party payors about the value of peers. And how to purchase the services in a value-based and sustainable way.

Joe Powell

Mr. Powell is the President of Association of Persons Affected by Addiction (APAA). He stated that in addition to financing of peers, there needs to be financing of recovery community organizations which serve as the support system for peers. Other needs are equity, wellness services and addressing SDoH needs.

Amy Brinkley

Ms. Brinkley is a Recovery Support Systems Coordinator with the National Association of State Mental Health Program Directors (NASMHPD). She previously worked for the Indiana State government. She noted that while many in this room have concerns about systems, there are peers in decision-making roles that are pushing internally within these systems to support peers. And that includes improving financing.

*Share how you have been working to improve financial sustainability for peers.*

Joe Powell

It is important to leverage relationship at all levels (Federal, State and local). These relationships helped towards building an infrastructure, then getting services billable as well as increasing placement opportunities. The relationships go beyond advocacy. They help educate decisionmakers and reduce stigma.

Greg Williams

In 2007, the Center for Medicare and Medicaid Services (CMS) issued a letter providing guidance to States on Medicaid reimbursement for peer support services. States are the decisionmaker, but the Federal CMS carries a lot of influence. Today, 49 States have peer support as Medicaid service. He noted that many States require supervision to be done by clinicians.

Mr. Williams also noted that Medicaid can be used to creatively purchase other services such as housing.

### Amy Brinkley

In her role with a national association, Ms. Brinkley gets to see State innovations. For example, in Illinois, the State invested \$11 million with a university to develop peer programming and internships. They expected to train 200 individuals but now have trained 800. In her prior State role in Indiana, there was no budget nor data so she tried to advocate for funding. It was right at the beginning of the COVID pandemic and inmates were being released from jails. It was an opportunity to provide peer support. After implementing the program and providing data, leadership saw the value of using peers.

### Dana Foglesong

Ms. Foglesong cited several barriers in financing peer support services. One is that the "in the community" nature of peer support services makes it difficult to fit into 15-minute billing units. She noted that peer run organizations often offer the best environment for peer support specialists to work in, but they are typically not Medicaid providers. Block grant and opioid response funding is more flexible but is not as sustainable. Smaller nonprofit and peer run organizations need additional support in navigating funding pathways.

*With financing, we shouldn't change the service. It is the system that needs to change.*

Dana Foglesong

### Lauren Foster

The three main barriers to private payor financing have been provider buy-in, cost and lack of workforce. Pilot studies can help demonstrate effectiveness and create buy-ins. They also can help demonstrate return on investment. They also will recognize that the workforce is a vital component and make efforts to maintain the current workforce (e.g., pay) and prime the pump for new peers. But this all takes time.

As an innovation, Ms. Foster noted that they had an app that allowed individuals to read a bio and do direct online scheduling with a peer specialist. Another innovation was a zero cost care approach for in-network use of peers.

*What is your dream scenario for funding peer support?*

- Peer support is available in all settings and there is braided funding. The goal is that the "right people get the right funding."

- There is asset mapping of RCOs and needs so peer services can be transferred to where the most need is.
- Have annual or monthly value-based payments rather than fee for service which is a common financing approach for public safety net services. Build up the infrastructure. Also allow for more than 15-minute increments
- Serve peers before a crisis rather than always working within an acute care model. Financing should allow for fidelity and integrity rather than forcing peer services to fit into funding models
- How can we have a more value-based model. Would also like to see peers in hospice/palliative settings.

### Discussion

Participants then had an opportunity to provide questions and comments.

- **Denied Claims** – One participant who runs an RCO noted that Medicaid billing is frustrating (e.g., sorting out denied claims) and not worth the effort. She had met with State legislators, but it is still not a viable option because of the administrative burden.
- **Fidelity** – While it was mentioned during the presentation, a participant echoed the concern that trying to accommodate funding requirements may pressure peer services to shift away from fidelity and authenticity.
- **Value of Champions** – A participant shared that the North Carolina Single State Agency Director promoted peers and was able to get media coverage about it. As a result, they were able to get the funding written into the system.
- **Infrastructure** – The strongest RCOs are often the ones that are given infrastructure money on the front end. SAMHSA’s block grants should have a recovery set-aside just as there is a set-aside for prevention. Without it, States will make other choices with the money.
- **National Leadership** – While States often make the decisions on behavioral health, there is a need for Federal leadership to help to bolster the system.
- **Recognizing Diverse Peer Leadership** – One participant shared that it is important to honor those within marginalized communities who have made significant inroads but are not recognized (e.g., the Zuni Federation of Mental Health).
- **Certified Community Behavioral Health Centers (CCBHCs)** – One participant asked how peers could be leveraged in CCBHCs (e.g., outsourced to peer agencies). Peers have value but should not be marketed as the solution to the clinical workforce issue.
- **Need to be at the CMS Table** – Several participants emphasized that peers need to be more engaged with CMS.
- **Sustaining the Office of Recovery** – Ms. Fogelson shared that the Office of Recovery is not codified into statute though there is a need to address this.

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## DAY TWO

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### Day Two Welcome

Brandee Izquierdo, Director of Behavioral Health at Pew Charitable Trusts served as the moderator for Day Two. She shared several high-level takeaways from Day one.

#### Authenticity

- Equity and inclusion focus may result in more diversity.
- Funding sources impact peer drift.
- More discussion is needed on the authentic human experience versus the authentic peer experience.
- There is discussion on whether to have peers integrated into a system or infused (e.g., provided by RCOs).

#### Financing

- There is a lack of flexibility of funding.
- There is a need for funders to be more accountable to those they fund.
- Funding impacts authenticity
- Infrastructure funding is needed, for RCO/PRO's
- There are different types of funding for peers in various settings.

#### Peer to Career

- The career ladder is hierarchical in nature and in messaging.
- Peer to Career implies that peers are an entry level position.
- Is being a peer an identity or a relationship (e.g., place the focus on the person being served)?

Dr. Izquierdo then opened the discussion for participant comment:

- **Authenticity** – There is a need to refocus peers on the lived experience to ensure that the umbrella didn't become so large that the workforce becomes meaningless.
- **Recovery** – There is a lot of overlap with recovery and peers. Recovery must be integrated into the continuum of care rather than an appendage to treatment. Peer services which can span across the continuum can help with that.
- **Maturity** – As with every human experience, people change and evolve. The participants noted that he was a different peer when he was just two years in recovery compared to now when it has almost been 20 years.



- **Concern by Black and African American Participants** – Several Black and African Americans expressed frustration and tension around the need to fully integrate DEI considerations and that there are still vestiges of White supremacy.

*Being a peer really should be centered around the person you serve. If a person is homeless, I don't check their identity of color. I ask them what they need and provide it if I can. -Participant*

## Federal Representatives Panel

Through a series of guided questions from Dr. Izquierdo, panelists shared how Federal efforts support the peer workforce.

*Share what your agency is doing to support the peer workforce.*

### Lorraine Smalls

Ms. Smalls is a Project Officer/Public Health Analyst with the Health Resources & Services Administration. She shared that HRSA has programs to help with burnout for clinicians. This has included community health workers. Examples include the use of apps; programs to foster emotional regulation and distress tolerance; and leveraging data to highlight the concern.

### David Awadalla

Mr. Awadalla is a Public Health Advisor with SAMHSA's Office of Recovery. One of his responsibilities has been to develop the National Model Standards for Peer Support Certification. This was personally important to him because he is in recovery from SUD and had been incarcerated. He was able to receive quality care and peer support. He emphasized that these discussions have life-or-death implications.

He went on to explain the process for developing the Model Standards.

### Gina Graham

Dr. Graham is the National Director for Outpatient Services & Psychosocial Rehabilitation with the Department of Veterans Affairs. She noted that the VA is the largest employer of peer specialists. While most are male, they are intentionally working to expand the pool of female peers. In addition to peers, the VA approach is to rely on strength-based programming and use interdisciplinary teams.

The VA offers to cover the certification and training costs as well as for the supervised apprenticeship. Peers often supervise other peers.

### Sean Lynch

Dr. Lynch is a program officer with the National Institute on Drug Abuse (NIDA). He shared that the Helping to End Addiction Long-Term (HEAL) initiative has a Notice of Special Interest

(NOSI) related to research to identify, develop, and/or evaluate strategies that address challenges with recruiting, training, and retaining a robust and highly qualified behavioral health workforce.

He added that NIDA’s Justice Community Opioid Innovation Network (JCOIN) and Consortium on Addiction Recovery Science (CoARS) initiatives have components focused on the peer workforce. Emerging findings from the Innovations in Recovery through Infrastructure Support (IRIS) study that was part of CoARS shows that ongoing efforts are needed to increase peers’ compensation, reduce stigma, and facilitate upward mobility, as well as address SDoH.

He provided several data points that should be tracked to demonstrate peer effectiveness.

### Lindsey Baldwin

Ms. Baldwin is with the Centers for Medicare and Medicaid Services (CMS). She noted that CMS has five new payment codes that offer reimbursement, and they are currently a proposed rule which is soliciting public comment.

### Discussion

Participants then had an opportunity to provide questions and comments.

- **Inclusion of ASL Services** – It was recommended to include reimbursement for ASL services to supplement peer services for individuals who are deaf or hard of hearing.
- **Individuals with Disabilities** – An individual with a visual impairment echoed that Federal agencies need to do more to support the disabilities community beyond just providing a 508-compliant website.
- **Federal Jargon** – It was noted that there has been a lot of acronyms and terms that are unfamiliar to many in the room, and it would be helpful to have a cheat sheet of terminologies.
- **Need for Medical Necessity** – The medical necessity requirement implies a diagnosis, and this does not work for peer services. They need to get access to the family and address SDoH before any diagnosis may be assessed.
- **Model Standards** – States were encouraged to build reciprocity across States so that peers have greater work flexibility.

*Peers should be embedded in systems rather than integrated. That is, they aren't hired by the system but work for a community organization that will provide oversight, even when they work in a system setting.*

Robert Ashford

## **Breakout Sessions**

Participants were again able to self-select participation in breakout sessions to discuss issues of authenticity, financing, and peer to career. These notes are also in Appendix B.

## **Peer to Career Panel**

Through a series of guided questions from Dr. Izquierdo, panelists responded to peer career issues (e.g., pay scale, retention, career ladders, etc. )

*Provide an introduction and overview of your work related to peer career needs.*

Mark Attanasi

Mr. Attanasi has been in recovery for 25 years. He is currently the CEO of IC/RC which provides peer credentialing exams. He noted that over 10K peers have been certified through his organization. He noted that when SAMHSA published its model standards, the IC&RC quickly adopted the standards.

*It is a myth that all peers want to be counselors. Many just want to be peers, but with a career ladder.*

Mark Attanasi

The IC&RC has also been focused on expanding the career ladder, particularly the role of peer supervisors.

Mark Jenkins

Mr. Jenkins is the CEO and Founder of the Connecticut Harm Reduction Alliance. He is a disabled veteran in long-term recovery. But he had spent extensive time “in systems” (e.g., psychiatric facilities and jails).

He noted that he and others in this room are Harm Reduction Ambassadors and often feel like outsiders within the peer movement. He added that data has shown their impact. He also said that youth speak a different language and “abstinence” may not resonate with them.

*Harm reduction service work is based in love and a refusal to be judgmental.*

Mark Jenkins

Kelly Davis

Ms. Davis is Vice President of Peer and Youth Advocacy with Mental Health America. She noted that she was five years in recovery before she began practicing abstinence.

She is a mental health peer who also experienced child sexual trauma. She noted that one aspect that peer workers provide which other positions do not is the rights of the individual. She voluntarily entered a facility and they committed her. She wasn't aware that could happen. She also said that systems often emphasized the message that “something is wrong with me” which creates self-loathing. Peers help protect and educate individuals to reduce these harms.

*Those with mental health issues are often told they can manage their illness rather than they can be in recovery.*

Kelly Davis (paraphrase)

Ms. Davis would like to see more research and advocacy done to support peer work. She also expressed concern about systems which are really driven around “illness navigation.” She noted that research shows that peers are passionate about their work, and it is not just low pay that is problematic. They are misunderstood and treated poorly.

Regarding self-care, it is often talked about, but it is placed as a responsibility of the individual. Rather the systems need to be accountable. Peers can't engage in self-care when they work in toxic environments or are put in situations without boundaries.

### Jose Flores

Mr. Flores spent 13 years incarcerated and currently services as a Recovery Support Specialist with Texas Health and Human Services.

He noted that the peer workforce provides a community for each other and a critical mass to advocate against the system of injustices. For example, in Texas, the peer community support each other in training and finding jobs. Recovery, particularly for those who have been incarcerated can be isolating.

He noted that education can be a barrier as well as a criminal record. He shared that his brother was released from Federal prison last year and was enthusiastic about doing peer work, but his offense was a barrier.

### Bill Stauffer

Mr. Stauffer is the Executive Director of the Pennsylvania Recovery Organization Alliance (PRO-A). He is in long-term recovery and lost two family members from addiction.

Mr. Stauffer said that peers are bound by their history. This is the asset they bring, but also the pain. He also shared the history of the larger peer movement and reminded participants that the peer movement was born out of the failings of the system to take care of individuals (e.g., [the Hughes Act](#)) and it was individuals in recovery who fought hard for these reforms.

*Peers are put into situations where they are fighting each other for scraps... We are blamed when we aren't doing well, and this is a form of discrimination.*

Bill Stauffer (paraphrase)

That power needs to be reclaimed for this current work. But instead, new peers are being taught a false less empowering history of the peer movement.

### Discussion

Participants then had an opportunity to provide questions and comments.

- **Not Everyone in Recovery is a Good Peer Worker** – Several participants shared that some peers are condescending or will try to impose their recovery pathway on a person they are serving (e.g., you must go to 12-steps).
- **Working in the System** – There is value of working within systems to impact change.
- **Funding Stays on Top** – Government funding streams often go from National to State to local and then community. Too much of it doesn't get to the community.

*There are allies within the systems and there is value in trying to infiltrate systems to provide reform from within.*

Amy Brinkley (paraphrase)

- **Supervision Approach Different for Peers** – One participant noted that clinical supervision of other roles is about case supervision.
- **Abstinence Requirement** – Abstinence gatekeeping can be a barrier.
- **Unionize Peers** – It was noted that mental health and SUD services were built on the “backs of unpaid labor.” Peers need to be recognized for their value. As an example, practicums should be paid positions.
- **RCOs Protection of Peers** – It was noted that many peers are single moms and don’t have time for self-care. Her RCO pays staff for 40 hours for 32 hours of work. Therapy appointments are paid for.
- **Reaching Out to Youth** – Many youth aren’t even aware that being a peer is a career path. The public is also largely unaware of what peer services are.
- **Peer Values** – There is a need for the peer workforce to be values-based to prevent co-opting of the movement.
- **SAMHSA’s Office of Recovery** – Several participants noted that the Office of Recovery has created space to allow peers to unite forces and have conversations, even those discussions that are uncomfortable or contentious.

*How are peers supposed to practice self-care when they aren’t given the time and space to do that?*

Racquel Garcia

*Sometimes little things matter. When I’m at a meeting at the SAMHSA building and go out to smoke a cigarette, I don’t want my security liaison to judge me. This is an example of harm reduction and reducing stigma.*

Brandee Izquierdo (paraphrase)

### Final Thoughts: Identify a Priority

As the meeting closed, participants were asked to identify one priority that they would like SAMHSA to support.

- How to coordinate a movement with many individuals to work collectively together?
- Advocacy with States and partners like the Department of Labor and Justice so everyone is on the same page and understands issues like authenticity and protection for peers.
- That there is a mechanism for different stakeholders in the room to share information, most notably those that related to policy.
- Provide a bridge so that peers can be at the table for CMS discussions.
- Work to be more inclusive. This is still a predominantly Caucasian movement.
- The [American Psychological Association](#) issued an apology for their role in structural racism. This might be something that the Office of Recovery could broker at the Federal level.
- A stronger push for harm reduction.
- It is true that people in this movement have love for others. It is also true that there is great risk of harm within the movement. How do we ensure the safety of the most vulnerable populations within this movement and the people we serve.
- Unlimited access to deaf needs by providing ASL interpreters and other accessibility accommodations.
- Integrate harm reduction principles into mental health approaches (e.g., it is about the individual identifying what “the problem” is and what they want us to do about it, while it is our job to walk alongside them and support them to live a full life.

- More inclusion, emphasis, and support for family/parent peer support, along with Youth Peer Support. Both are needed and should be promoted together.

## Appendix A – Participants List

**Van Asher**

Harm Reduction Consultant  
The Puerto Rico Project  
The Perfectly Flawed Foundation

**Robert Ashford**

Executive Director  
Unity Recovery

**Mark Attanasi**

Executive Director  
International Certification & Reciprocity  
Consortium

**Eric Bailly**

Senior Director  
Third Horizon Strategies

**Keri Ballweber**

Harm Reductionist  
Point to Point

**Sandi Bishop**

Peer Supervisor  
Horizons Mental Health Association

**Katie Boardman**

Director of Recovery Corps  
Ampact

**George Braucht**

Chief Mission Officer  
Brauchtworks Consulting

**Amy Brinkley**

Recovery Support Systems Coordinator  
National Association of State Mental Health  
Program Directors

**Jan Brown**

Executive Director  
SpiritWorks Foundation

**Linda Buchheister**

Children's Program Manager and Parent  
Peer Coordinator  
Kansas Department for Aging and Disability  
Services

**Cherene Caraco**

Chief Executive Officer  
Promise Resource Network

**Sierra Castedo de Martell**

Postdoctoral research fellow  
Chestnut Health Systems

**Jamie Chrisman**

Interim Executive Director  
Faces and Voices of Recovery Piedmont

**Wayne Cortez**

Peer Support Specialist  
Riverside-San Bernadino County Indian  
Health, California

**Sera Davidow**

Director  
Wildflower Alliance

**Livia Davis**

Chief Learning Officer  
C4 Innovations

**Sharah Davis**

Trainer  
Kansas Department for Aging and Disability  
Services

**Kelly Davis**

Vice President of Peer and Youth Advocacy  
Mental Health America

**Jessi Davis**

President of the Board of Directors  
National Association of Peer Supporters

**Johanna Dolan**

Chief Executive Officer  
Dolan Research International  
Steering Committee Member  
Peer Recovery Center of Excellence

**Wesley Evans**

Statewide Coordinator Integration and  
Recovery Services  
Florida Department of Children and  
Families

**Jennifer Farfalla**

Director, Overdose Surveillance and  
Prevention  
Association of State and Territorial Health  
Officials

**Michaela Fissel**

Executive Director  
Advocacy Unlimited, Inc.

**Jose Flores**

Program Specialist VII and Recovery  
Support Services Lead  
Texas Targeted Opioid Response  
Texas Health and Human Services

**Dana Foglesong**

National Senior Director, Recovery and  
Resiliency Services  
Magellan Health

**Lauren Foster**

Behavioral Health Program Manager  
Blue Cross and Blue Shield of Minnesota

**Racquel Garcia**

Chief Executive Officer and Executive  
Director  
HardBeauty & HardBeauty Foundation

**Courtney Gary-Allen**

Organizing Director  
Maine Recovery Advocacy Project

**Brandon George**

Director of Consulting  
Ascension Recovery Services

**Kathryn Goetzke**

Chief Hope Officer  
The Shine Hope Company and iFred

**Heather Gotham**

Director  
Mental Health Technology Transfer Center  
Network  
Clinical Associate Professor  
Stanford University School of Medicine

**Pamela Greenberg**

President & Chief Executive Officer  
Association for Behavioral Health and  
Wellness

**Ashley Grimes**

President & Chief Executive Officer  
NAMI Florida

**Jesse Heffernan**

Founder & Lead Facilitator  
Helios Recovery Services

**Joseph Hogan-Sanchez**

Director of Programs  
Faces & Voices of Recovery

**Caren Howard**

Director, Policy and Advocacy  
Mental Health America

**Jason Howell**

Executive Director  
RecoveryPeople

**John Hulick**

Senior Program Manager  
Palm Beach County Office of Behavioral  
Health & Substance Use Disorders



**Sarah Hussain**  
Director of CARE and PASRR  
Kansas Department for Aging and Disability  
Services

**Brandee Izquierdo**  
Director of Behavioral Health  
Pew Charitable Trusts

**Tom Jackson**  
Peer Recovery Programs Manager  
Western State Hospital

**Mark Jenkins**  
Chief Executive Officer  
Connecticut Harm Reduction Alliance

**Laurie Johnson-Wade**  
Co-Founder  
Lost Dreams Awaken Center

**Jessica Kelley**  
Policy Manager  
Association for Behavioral Health and  
Wellness

**Darcy Kues**  
Project Manager  
Peer Specialist Curriculum Development  
Addiction Research Institute  
South Southwest Mental Health Technology  
Transfer Center

**Nanette Larson**  
Deputy Director for Wellness and Recovery  
Services  
Illinois Department of Human  
Services/Division of Mental Health

**Karran Larson**  
Statewide Coordinator SUD and Recovery  
Deaf Hard of Hearing  
Bureau of Substance Abuse Services  
Massachusetts Commission on Deaf and  
Hard of Hearing

**Kyneta Lee**  
National Director of Peer Training  
Copeland Center for Wellness and  
Recovery

**Kris Locus**  
TAY Coordinator  
On Our Own Maryland

**Cortney Lovell**  
Director of Practice Improvement &  
Consulting  
National Council for Mental Wellbeing

**Stacey Manser**  
Senior Research Scientist  
Texas Institute for Excellence in Mental  
Health  
University of Texas at Austin

**Kevin McCarthy**  
Board President  
Massachusetts Organization for Addiction  
Recovery

**Shayn McDonald**  
Youth Program Specialist  
Youth MOVE National

**Te Jay McGrath**  
Youth Programs Specialist  
Youth MOVE National

**Daryl McGraw**  
Director  
Formerly, Inc.

**Steve Miccio**  
Chief Executive Officer  
People USA

**Brenda Moes**  
DBH Administrator  
State of Nebraska

**Chandra Monnett**

Recovery Support Specialist and Recovery  
Program Coordinator  
Communities for Recovery

**Susie Mullens**

West Virginia Collegiate Recovery Network  
Director  
Marshall University

**Keith Murphy**

Director, Alcohol, and other Drug  
Assistance Program at Rutgers-New  
Brunswick  
Rutgers University

**Keris Myrick**

Vice President of Partnerships  
Inseparable

**Yvette Patricia Pate**

Program Director  
National Association of Peer Supporters

**Laura Peters**

Deaf Certified Addiction Recovery Coach  
Niki Inc

**Sherrine Peyton**

Statewide Opioid Settlement Administrator  
Illinois Department of Human Services

**Joe Powell**

President & Chief Executive Officer  
Association of Persons Affected by  
Addiction

**Harvey Rosenthal**

Chief Executive Officer  
New York Association of Psychiatric  
Rehabilitation Services.

**Katie Rouse**

Executive Director  
On Our Own of Maryland, Inc.

**Kevin Rumley**

Executive Director, North Carolina  
Buncombe County Veterans Treatment  
Court

**Amanda Saake**

Chief Advocacy Officer  
New York State Office of Mental Health

**Arc Telos Saint Amour**

Executive Director  
Youth MOVE National

**Tim Saubers**

Program Coordinator for Workforce  
Development  
Peer Recovery Center of Excellence

**Ash Schemenauer**

Recovery Support Peer Specialist (Intern)  
Niki Inc

**Athena (Theo) Schwartz**

Transition Age Youth Coordinator  
Utah Department of Health and Human  
Service

**Lyndi Seabolt**

Program Coordinator  
Southern Plains Tribal Health Board

**Jenna Sheldon**

Consultant

**Eric Smart**

CARES Program Assistant  
Georgia Council for Recovery

**Sue Smith**

Chief Executive Officer  
Georgia Parent Support Network, Inc.

**Amy Spagnolo**  
Project Director  
Academy of Peer Services  
Faculty  
Rutgers University

**Len Statham**  
Chief Operating officer  
New York Association of Psychiatric  
Rehabilitation Services

**William Stauffer**  
Executive Director  
PRO-A

**Millie Sweeney**  
Director, Learning & Workforce  
Development  
Family-Run Executive Director Leadership  
Association

**Karen Taycher**  
Executive Director  
Nevada PEP

**Morgan Thompson**  
Chief Executive Officer  
Prevention Links  
Board Member  
Association of Recovery Schools

**Stancil Tootle**  
Board President  
Bainbridge Advocacy independence, net  
work

**Adam Viera**  
Co-Director  
Peer Recovery Center of Excellence

**Mike Weaver**  
Patient Affairs Coordinator  
South Carolina Department of Mental  
Health

**Isha Weerasinghe**  
Senior Policy Analyst  
Center for Law and Social Policy

**Conni Wells**  
NE Regional Director  
Tennessee Voices

**Debra Wentz**  
President & Chief Executive Officer  
New Jersey Association of Mental Health  
and Addiction Agencies, Inc.

**Melanie Whitter**  
Deputy Executive Director  
National Association of State Alcohol and  
Drug Abuse Directors, Inc.

**Greg Williams**  
President  
Third Horizon Strategies

**Alexia Wolf**  
Executive Director, Behavioral Health  
Consortium  
Office of Lieutenant Governor Bethany  
Hall-Long

**Ajahrain Yellowhair**  
Youth MOVE National

*Federal Staff*

**David Awadalla**  
Public Health Advisor  
Office of Recovery  
Substance Abuse and Mental Health  
Services Administration

**Lindsey Baldwin**  
Hospital and Ambulatory Payment Group  
Centers for Medicare and Medicaid  
Services

**Sonia Chessen**  
Chief of Staff  
Substance Abuse and Mental Health  
Services Administration

**Lorraine Smalls**  
Project Officer and Public Health Analyst  
Health Resources and Services  
Administration

**Paolo del Vecchio**  
Director  
Office of Recovery  
Substance Abuse and Mental Health  
Services Administration

**Wanda Finch**  
Special Expert  
Office of Recovery  
Substance Abuse and Mental Health  
Services Administration

**Gina Graham**  
National Director  
Outpatient Services & Psychosocial  
Rehabilitation  
Veterans Health Administration

**Kristen Harper**  
Public Health Advisor  
Office of Recovery  
Substance Abuse and Mental Health  
Services Administration

**Miranda Herrera**  
Regional Behavioral Health Advisory  
Office of Recovery  
Substance Abuse and Mental Health  
Services Administration

**Sean Lynch**  
Program Officer  
National Institute on Drug Abuse

**Christina Ramsey**  
Public Health Analyst  
Health Resources Services Administration

## Appendix B – Breakout Session Reports

### Authenticity

*How do you define peer identity?*

- Definitions include relationship, mutuality, connection, and social justice.
- Adhere to a set of values.
- Liberation and freedom.
- Starts with recognition of oppression.
- When we become part of the system of oppression, we lose authenticity.
- Critical thinking lens.
- Cultural congruence.
- Intentional outreach to communities.
- Intersectionality...including with individuals who have different abilities and more visible or stigmatized disabilities and marginalized identities

*Discuss issues of integration within clinical systems*

- Integration goes wrong more than it goes right.
- Social justice is at the core.
- Flip the script. Rather than peers invited into clinical environments. Clinicians should be invited into peer environments.
- Being co-opted.

*Other Comments*

- Understanding what ‘need’ means with nuances and terms.
- Reciprocity needs to also include tribes.
- Alternatives Conference no longer sponsored by SAMHSA.
- Need more ways to get together on a national level to strategize and advocate.
- Specialty peer support (e.g., harm reduction, post-partum).
- Native Americans don’t have a certification training.

### Financing

- Need to pay for ASL interpreter services.
- Infrastructure considerations.
- Fee-for-service methodology is a mismatch because of potential exclusions related to the requirement for “medically necessary” services.
- Lack of flexibility with funding restrictions.
- There needs to be accountability for outcomes, including funding.
- It helps to have civic/leadership support.
- Advocacy
- Leverage opioid settlement funds. ([nationalopioidsettlement.com](http://nationalopioidsettlement.com))

- Challenges with philanthropy reporting requirements – The Association of Foundations came together to minimize the requirements.
- Getting specific about reporting requirements.
- TA to get grants/requirements.
- Braided funding and strategies to diversify.
- Getting at the CMS table early so we can make sure it works for us.
- Infrastructure funding pathway.
- Rural RCO support (Indiana, Maine, New Hampshire).
- Independent practice associations.
- Underinsured communities.

### Peer to Career

- Peer is not an identity. It is a relationship.
- Career ladder means upward mobility.
- Everyone needs economic stability.
- System approves workforce expansion. A systematic reaction rather than creative approach.
- Do I lose my “peerness” when I’m not doing direct services? We need more “peerness” inside the system. But how do we create this when we have a system that doesn’t want us to exist?
- Break down barriers to create the careers that people want.
- There is a difference between the peer movement and the peer workforce.
- Peer pathways versus careers.
- Unpack the internalized stigma in our own movement.
- Mutuality versus power over.
- Career means a process of opportunity.
- Explore “the weight” we’ve put on the workforce. Data show that certification is not moving us professionally.
- If certification doesn’t improve our art & skill, is there another option?
- Everyone doesn’t need to be certified.
- There are discriminatory policies re: certification. Private groups benefitting. Lack of DEI (e.g., LGBT training).
- Certification is valuable and empowers peer specialists.
- How can we be a peer and clinician or case manager?
- Direct services - level of scale requires a level of bureaucracy. The demand is bigger than our advocacy to dismantle.
- Scaling issues and pathways.
- What are we protecting the public from?

### Peer to Career (Virtual)

Major Themes: Honor individual/individuality if lived experiences/unite on fundamental beliefs, treating people with acceptance. Empathy. The work we do and the way we do it is the distinction from other parts of the system, focus on our foundations in social justice, creating

healing environments, being our true selves and ongoing learners who evolve from and with people we help, partnership leverages an independence of function/operations based on values – the interdependence for partnership with other providers makes them need to listen. Tradeoff is non-integrated cannot influence other parts of the system as much which impact success on the piece they have)

*What does peer to career mean to you?*

- Training and community. Feeling the spirit of the peer community and the movement while attending the peer trainings is empowering.
- The career is also part of a wellness journey and pathway to recovery, a significant support was finding organizations that have peer support and having allies and mentors throughout the way.
- Meeting other people who believe in this profession and support those with lived experience to help them practice and grow.
- As peer sharing experience in all the various spaces including state entities and funders is empowering for a career.
- Trying to go back to basics for peer support and on how integrate peer services into clinical work while maintaining authenticity.
- Being in the room with this community with similar experiences ignites the fire of passion for this field.
- Stigma/ discrimination is a barrier to stay within this profession and to grow. How do we decrease the discrimination and education bias for the role of a peer to allow them to grow and make this into a career because peers are leaving this field for better pay and better work environment where they do not have to continue to advocate and fight to prove their value within their agency.
- The education bias halts any career advancements and better pay.
- Being able to make a living wage is the beginning of the process of peer to career.

*What are the various components or priority areas that we should discuss in developing peer support specialist and recovery coaching career goals?*

- Decreasing the stigma/discrimination within the profession.
- Fair pay.
- Peer support- distinguishing the difference between identities/experiences and the actual support workforce. The support part of the workforce requires a connection and disclosure to create connection. Support as a valuable service while the word peer is a noun that refers to people identity or experiences so how they use their experience to provide support is an important aspect of the work.
- Referring to the Document “maintaining our roots”- peer support grew on its own and grew beyond the capacity of the volunteer initiative which increased the demand for the paid services. Specializing and certification in peer support is essential for the advancement and value of the profession.

- It's about facilitating peer support to those we serve and not only being a peer. Acknowledge its value in society and embedding mechanisms throughout the system that values and recognize the need for peer support.
- There's no mandate for peer operated agencies and it's the best environment for authentic peer support as compared to Medicaid mandates for peer services.
- Leadership/supervisory roles- the mechanism for the experience in providing supervision, that includes experience in providing peer support and not based on a clinical background. Peer operating agencies should play a role in developing that mechanism.
- Developing clear job descriptions that are created by those who do the work and not clinicians who believe they know what peers are supported to do.
- The challenge is on the system level and the clinical/medical oversight for this field and their values are the ones that are predominant and that determines where the funding goes. Part of the challenge as peers is to be able to demonstrate our values and worth to the clinical roles.
- It's about helping peers learn how to function in multidisciplinary teams and to keep their authentic work and it can be a lonely space if they're the only peer on the team. That's the element of training that gets overlooked. Teaching peers how to advocate for their worth and their role in front of other professionals. Having a support system that offers a safe space to have these conversations and the needs of this profession. There's a notion that peer support is a non-clinical enhancement to the clinical services, but it needs to be looked at that we are as valuable as clinical services to get respect to elevate our positions.
- There is more research demonstrating the effectiveness of peer support than there is on another professional helping role. We need to work harder to educate more people on this research because most other professionals do not know about the evidence for our efficacy. It has also been shown in other professions like HIV peers and criminal justice peers, the peers need to continue to educate themselves to help advocate for their role.