

Addiction Recovery Peer Service Roles: Recovery Management in Health Reform

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Addiction Recovery Peer Service Roles: Recovery Management in Health Reform

Overview

Addiction Recovery Peer Service Roles: Recovery Management in Health Reform synthesizes and integrates the insights, challenges and ideas generated at the July 1, 2010, White House Office of National Drug Control Policy and Faces & Voices of Recovery Roundtable on Peer Recovery Support Services. Local, state and federal officials are embracing a new orientation toward recovery from addiction as the nation begins to implement health care reform. The roundtable provided an opportunity to raise the profile of new services developed by recovery community organizations to support people seeking or in recovery from addiction – services that exemplify this new recovery orientation.

The deliberations were instrumental in the development of a more focused peer service continuum and of specific service roles. This paper includes detailed descriptions of the components of the peer recovery coach service role and peer-operated recovery community centers as a concrete service. This direction was also informed by the positioning of peer services by the Substance Abuse and Mental Health Services Administration (SAMHSA) in health reform implementation, particularly in the domains of 1) peer supports and 2) peer-operated services.

To support the development of these service roles, Faces & Voices plans to accredit organizations that are delivering peer recovery support services. This process will equip and protect organizations and individuals acting in a service capacity while guaranteeing quality services to purchasers. In keeping with SAMHSA's new service priorities under health care reform, this undertaking's priorities are: development of service standards and measures; securing of funding and reimbursement sources, and establishment of a firm research base that incorporates evidence-based practices.

Peer recovery support services are making a difference in the lives of Americans from all walks of life.

Eve was 16 years old when she started using drugs and alcohol. At age 36, she ended up in jail for two months as a result of her crack use. She entered a 28-day treatment program and left feeling optimistic. However, her home and community environment were not supportive of her recovery and she started using again. After another episode of jail and treatment, Eve was determined to use the tools that she had learned. She started getting help from a peer recovery coach who helped her develop and update a recovery plan that she started before her release. Her recovery coach helped her to arrange recovery housing for six months until she was released from parole. Eve felt comfortable calling her coach whenever she needed help. The coach helped Eve access a number of jobs and even arranged for a car to be donated to help her get from job to job. With the peer coach's help, Eve started to save money, fix her bad credit, and become independent and trustworthy.

Today Eve is employed full time and serves on the board of a recovery house. She helps other people get out of jail and gain their independence. She's a registered voter and responsible community member. Her son is back in her life and she has gained the trust of her family and friends. She has made new friends in recovery. With help and direction from her peer recovery coach, Eve started the journey back into life. Eve said, "Peer recovery support services are crucial for someone who has been where I have been. They give you support, direction, and a plan. With peer recovery support services, people like me have a chance."

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Introduction

Over the last ten years a growing number of RCOs have pioneered the development and delivery of peer recovery support services for people seeking to achieve long-term recovery from addiction to alcohol or other drugs. These services are improving opportunities for individuals and families by bridging the gaps and providing support with transitioning from incarceration or other institutions through treatment into long-term recovery.

Peer recovery coaches and recovery community organizations go where no other agencies go: in the streets, homeless shelters, jails and churches. They engage people who no one else would help.

– Joe Powell, Executive Director, Association of Persons Affected by Addiction, 2010

I. What Differentiates Peer Recovery Support Services?

Peer-based recovery support is the process of giving and receiving nonprofessional, nonclinical assistance to achieve long-term recovery from severe alcohol and/or other drug-related problems. This support is provided by people who are experientially credentialed to assist others in initiating recovery, maintaining recovery and enhancing the quality of personal and family life in long-term recovery (William White, 2009).

Peer recovery support services are strengths-based, build recovery-oriented systems and offer hope. They are adaptable across the continuum of care and are distinguished from professional treatment and mutual aid support groups.

Distinguished from Professional Addiction Treatment Services

Professional services are provided by individuals with formal education in a clinical/medical setting. The treatment services offered reflect the treatment philosophy of each service provider, including primary care physicians. Professionally-directed treatment providers are accredited and licensed to provide those services. Their staff/counselors are credentialed, licensed and/or certified. While some addiction professionals in long-term recovery may volunteer to provide peer recovery support services, they would not be acting in their professional capacity. If they took on this role, they would need to rigorously manage issues of role ambiguity and conflict.

Distinguished from Mutual Aid Support

Mutual aid is provided in a group setting by individuals with experiential knowledge within a particular community of recovery. In a mutual aid setting, support is based on the beliefs and practices of a particular recovery fellowship such as Alcoholics Anonymous or Smart Recovery. “Service work” in the context of mutual aid differs from peer recovery support services because it is based in a particular fellowship and part of a personal program of recovery. Some people who are peers and/or receiving peer recovery support services are also members of mutual aid groups. Their work as a peer helper is distinguished from the service work they may provide within their particular recovery fellowship. Peer recovery support services should not replace support provided by sponsors or other indigenous community support resources.

Peers serve functions different from those of sponsors found in 12-step mutual aid groups:

- Sponsors operate in relative isolation from professional helpers
- Sponsors provide support within a particular fellowship, emphasizing the viability and superiority of the particular program or fellowship as a framework for successful recovery
- Sponsors’ support is limited to those who have “a desire to stop drinking” and to those who have sought help within a local recovery program or fellowship
- Sponsors’ primary focus is on the use of 12-Step Tools (personal story sharing, meetings, step work, literature, fellowship)
- Sponsors are not allowed to be reimbursed for providing support
- Sponsors are guided by historical and contemporary practice as expressed through literature on sponsorship as expressed in a group conscience and are not held accountable by formal organizational codes of ethics (from White, W. Sponsor, Recovery Coach, Addiction Counselor)

When are Peer Recovery Support Services Delivered?

Peer recovery support services can be delivered across the full continuum of recovery, regardless of whether or not a person uses clinical treatment services. Peer recovery support services span pre-recovery identification and engagement, recovery initiation and stabilization, recovery maintenance and enhanced quality of personal and family life in long-term recovery. They can be offered before an individual enters treatment or when they are waiting for a service opening. They can coincide with treatment services, enhancing engagement and retention and providing a connection to community while a person is in treatment. Following treatment, peer recovery support services help people manage their own recovery by developing recovery skills, accessing resources to support ongoing recovery and giving them an opportunity to further enrich their recovery through volunteer work in recovery support settings.

For the millions of Americans who are not receiving clinical treatment for whatever reason, peer recovery support services provide an invaluable community network (including or in lieu of mutual aid groups) and infrastructure for recovery initiation and maintenance. Peer recovery supports as an alternative to professionally-directed addiction treatment services may be particularly viable for those persons with lower problem severity and complexity and higher recovery capital (sum total of internal and external resources to initiate and sustain long-term addiction recovery).

Peer recovery support programs are an important mechanism for increasing individuals’ self-efficacy beliefs and decision-making capabilities. Evidence shows that seeing or visualizing those similar to oneself successfully performing activities typically increases a person’s belief in his or her own ability to perform those activities successfully.

II. Who Is Delivering Peer Recovery Support Services?

Services are delivered by people with the lived experience of recovery from addiction to alcohol and other drugs, either as a person in long-term recovery or a family member or significant other. There is a mutuality to peer recovery support, with the person giving and receiving support benefiting from the interaction. Whether paid or volunteer, there are various levels of training offered to peers who are providing services. Organizations that have an all-volunteer peer base have paid staff whose primary job is to train and supervise volunteer peers. In a growing but limited number of states (22), there are certified peer addiction recovery support specialists.

There is an historical precedent for people in recovery from addiction who are members of mutual-aid fellowships serving in their professional lives as outreach workers, case managers, counselors, crisis workers, job coaches, residential managers and research assistants.

Nonprofit RCOs governed by the recovery community are delivering the vast majority of peer recovery support services. Other entities include:

1. Nonprofit organizations focusing on the service needs of specific populations, including women, individuals with HIV/ AIDS or mental illness and people with experience with criminal justice and/or child welfare systems
2. Publicly-funded addiction treatment programs
3. Private addiction treatment programs
4. Organizations that once specialized in conducting pre-treatment interventions on a fee basis and are now expanding their services to include post-treatment monitoring and support

III. Where Are Peer Recovery Support Services Delivered?

Peer recovery support services are being delivered in urban and rural communities to many different population groups defined by age (adolescents); race or ethnicity (Native American, Latino, African American); gender and sexual orientation; and/or co-existing conditions/status such as incarceration, homelessness, mental illness or HIV/ AIDS.

Many RCOs have established recovery community centers where educational, advocacy and sober social activities are organized. Many provide space for mutual-aid meetings, sometimes at a fee. These organizations offer peer recovery support services delivered at the recovery community center. These recovery community centers are helping people engage and sustain their recovery, engaging families and significant others, bridging the gap between treatment and long-term recovery and supporting people reentering the community from incarceration. Peer recovery support services are also offered in churches and other faith-based institutions; recovery homes/ sober housing; jails and prisons; probation and parole programs; drug courts; HIV/AIDS and other health and social service centers, and addiction and mental health treatment agencies.

IV. Who Pays for Peer Recovery Support Services?

A variety of public and private funding and reimbursement streams support peer recovery support services and recovery community centers:

A. Federal and State Grants and Appropriations

Since 2002, the main source of funding has been SAMHSA's Recovery Community Services Program (RCSP) initiative. Grantees cycling off RCSP funding have developed various means of sustaining their programs. For example, the Association of Persons Affected by Addiction (APAA) is funding its peer services to people with co-occurring disorders through a contract with Value Options, a managed care insurance company. Connecticut Community for Addiction Recovery (CCAR) receives state funding (criminal justice and health) to deliver specified peer services. Pennsylvania Recovery Organization – Achieving Community Together (PRO-ACT) receives funding from the City of Philadelphia for its recovery community centers in addition to its current RCSP grant. As the RCSP-funded initiatives developed, other RCOs were founded, many with a mission of developing and delivering peer recovery support services. The demand for RCSP grant awards has grown dramatically, with over 200 applicants for six awards that are to be announced in the most recent round of funding.

Another SAMHSA program, Access to Recovery (ATR), begun in 2004, has been instrumental in developing (mostly non-peer) recovery support services. As this voucher program gains traction, there is a possibility that more ATR-granted states will have access to former RCSP grantees and other RCOs and make available peer recovery support services as part of their comprehensive service menus. Because of the nature of a voucher program, providers in an ATR network cannot rely on dependable and consistent funding from this source.

In addition, the states of Vermont, Massachusetts, New York and Virginia are funding recovery community centers where peer recovery support services are delivered. Vermont's centers, organized as The Vermont Recovery Network, are funded by the state legislature. The initial funding for three centers came in 2001 and has grown over the last nine years to support today's network of nine peer-run recovery centers. Finally, as peer recovery support services are becoming more prevalent on the service landscape, RCOs are obtaining service contracts from state, county and municipal agencies.

B. Private Pay

People are paying out-of-pocket for peer recovery support services delivered through for-profit businesses such as Sober Champion (www.soberchampion.com), one of a growing number of such businesses.

C. Medicaid Reimbursement

(CMS Memo to State Medicaid Directors, SMDL #07-011, 8.15.07)

Primarily routed through the following authorities:

- Section 1905 (a) (13) – the rehabilitation services option
- Section 1915(b) Waiver Authority – managed care/freedom of choice waivers
- Section 1915 (i) Deficit Reduction Act Authority

Stipulations:

5. Supervision – by state-defined competent mental health professional
6. Care coordination – including person-centered recovery service plans with individualized goals and measurable outcomes

7. Training and credentialing of peers (and continuing education requirements) – as defined by state

V. Types of Peer Recovery Support Services and Service Roles

Salzer (1997) noted that peer services fall into four social support domains:

- **Emotional** – supports that foster hope, resiliency, confidence and self-esteem
- **Informational** – develops knowledge and skill-building
- **Instrumental** – provides concrete assistance with housing, transportation, employment, etc.
- **Affiliational** – fosters community kinship and social inclusion

For example, a project that is planning social support services to address recovering people’s employment needs might consider whether a job referral (informational support) by itself is adequate, or whether emotional support (such as supportive coaching to prepare for an interview), and/or instrumental support (such as help cleaning up a criminal record) might also be needed. In general, the more robust the types of social supports available to address any given recovery concern, the more likely that a person seeking help will walk away with useful information, a new insight or skill, or more confidence to help with the tasks ahead.

In keeping with SAMHSA’s service priorities in health reform, two pertinent peer service roles have been developed:

8. Peer recovery coach
9. Peer-operated recovery community centers

Table 1, below, links each of these service roles with social support domains and identifies the unit of support.

TABLE 1 – SERVICE ROLES

Service Role	Social Support Domain	Unit of Support
Peer Recovery Coach	Emotional Informational Instrumental Affiliational	Individual
Peer-Operated Recovery Community Centers	Emotional Informational Instrumental Affiliational	Individual Family Community

VI. Peer Recovery Coach

Individuals serving as peer recovery coaches balance three overarching service roles:

10. Personal guide and mentor for individuals seeking to achieve or sustain long-term recovery from addiction, including medication-assisted, faith-based, 12-Step and other pathways to recovery
11. Connector to instrumental recovery-supportive resources including housing, employment and other professional and nonprofessional services

12. Liaison to formal and informal community supports, resources and recovery-supporting activities

Service Roles

- Provides emotional and social support, listening, sharing of recovery experience and teaching of how each individual possesses some of his/her own recovery capital to help sustain their recovery.
- Provides assistance in setting recovery goals and developing recovery plans
- Provides support in restructuring life and developing life and coping skills to facilitate recovery
- Provides help in developing recovery-supportive friendship, kinship and community networks
- Provides fluid links between treatment, peer recovery support services and mutual aid.
- Serves as role model and practical living example of recovery
- Facilitates access to services and resources supporting early recovery: housing, employment, education, etc.
- Provides connections to health (primary, dental, mental health, etc.), human service and other relevant systems, including criminal justice and child welfare
- Serves as recovery liaison to probation officer, social workers, child welfare agents
- Provides culturally appropriate and recovery-oriented health education
- Serves as advocate for individual and community needs
- Builds individual, family and community capacity for recovery capital via advocacy and organized community-based recovery activities

Value of Peer Recovery Coach Services

Peer recovery coaches highlight their personal and lived experience of recovery as a key component of their service role. This element, missing from other service settings, is central to why peer services are so effective, popular and successful. A service context that minimizes the power differential between coach and peer helps to create situations in which peers experience trust and are encouraged to make informed choices and guided decisions about the initiation and self-management of their own recovery. The relationship between the peer recovery coach and the person receiving services involves ongoing communication that entails check-ins on progress, identification of challenges and strategies to address them.

Peer recovery coaching should not be confused with case management. The coach has a broader and more comprehensive role and tasks than a case manager. Because the coach is available on a number of levels and in a variety of contexts (some recovery coaches are reachable on call 24 hours a day), the person receiving services is able to access recovery-appropriate systems, services and community resources with the assurance of monitored follow-up, balanced with ongoing guidance and support. Without sacrificing quality, peer recovery coaching can be offered in a time-sensitive and cost-effective manner. Further, because of the nature of the service relationship and setting, the peer recovery coach is able to engage individuals at critical – and often fleeting – moments of opportunity, providing continuity of contact in a supportive recovery relationship.

The level and type of service provided is different from what's available in the professional service context. The peer recovery coach highlights his/her lived experience, which is not in the role of the case manager. The case manager's work only falls in the instrumental domain, unlike the peer recovery coach, who fulfills all four domains.

- Services are often conducted in community and neighborhood settings, where the peer is located.

- Peer recovery coaches act in a liaison capacity by 1) directly initiating the individual to recovery community environments and even accompanying them as needed and 2) helping the individual navigate and often acting as a liaison to, services and systems, especially those lacking a strong recovery orientation.
- Peer recovery coaches act as a recovery and empowerment catalyst: guiding the peer's recovery process and supporting the peer's goals and decisions, rather than arranging and coordinating services or "doing for."
- Services are person-centered and strength-based. They identify existing recovery capital and build future capital. (For additional information, see *What Are Peer Recovery Support Services?* [Center for Substance Abuse Treatment].)
- Services are relationship-oriented, garnering a sense of trust, confidence, authenticity and efficacy, based on shared experience.
- Services promote the idea of an individual defining and directing his or her own recovery plan in a collaborative manner, backed with guidance, structure, support and navigation assistance.
- Individuals can be engaged in a timely and expeditious manner, at critical points of recovery vulnerability and throughout various stages of the recovery process.
- In the event of relapse, the individual can be shepherded back into appropriate supports and services in a timely manner.
- In many cases, individuals in long-term recovery performing service roles as peer recovery coach strengthen their own recovery, especially those who may be experiencing recovery challenges as a result of job loss, a death in family, empty nest, divorce or economic crisis. They may also derive a feeling of purpose and usefulness from their service to others, the so-called "helper therapy" principle.

TABLE 2 – PEER RECOVERY COACH

Program Requirements: Answers to SAMHSA-Posed Questions on Service Definitions	
Peer Recovery Coach	
1. Ideally, where should this service be provided? Why?	<p>Informal or personal space conducive to peer context and building trust, relationship; space should level power differential between peer provider and individual:</p> <ol style="list-style-type: none"> 1. Public community settings (e.g. recovery community center, public library, coffee shop, etc.) 2. Peer’s home or living situation 3. Telephone and other electronic communication 4. Jails and prisons 5. Emergency rooms 6. Primary care practices that treat addictions 7. College health centers 8. School settings 9. A clinical setting as long as there is a distinction between peer and professional services and there is a “dedicated” space where the peer services can be delivered
2. Where do you not want this service provided? Why?	Should not be provided in formal, professional, or clinical setting that would undermine peer relationship or would put confidentiality at risk.
3. How many clients should staff serve as part of this service (e.g., caseloads, group size)?	Caseload depends on peer recovery coach’s work/time status (volunteer or paid) and the level of need of the person receiving services. For example, a person employed 30 hours/week at one recovery community organization as a peer recovery coach handles a caseload of 15; a full-time person at another recovery community organization between 20 and 30.
4. In general, how often should an individual receive this service (frequent – several times a week, consistent – once a month, minimally – once every 90 days)	<p>Frequency of contact aligns with stage of recovery and can taper as recovery time progresses:</p> <ol style="list-style-type: none"> 1. Early recovery (1-6 months): Frequent – several times a week 2. Mid-recovery (6-12 months): Consistent – weekly 3. Stable (>1 year): Check up every 30-90 days, or as needed
5. When should this intervention occur (days, nights, weekends)?	Service should be provided to accommodate, when possible, the individual’s availability and work schedule: days, evenings, weekends, as appropriate

6. Is the service delivered face-to-face-only or are some activities performed on behalf of clients?	Service should be provided: 1. Primary: face-to-face 2. Secondary: telephone and other electronic communication No activities are performed on behalf of clients
7. In general, how long should someone receive this service before you review if there is progress towards the intended outcome?	Services should be reviewed at 6-month intervals.

Organization and Service Settings for Peer Recovery Coaches

As indicated in the table above, the ideal services settings for peer recovery coach activities are

13. Welcoming, nonprofessional and nonclinical public spaces and community settings (e.g., recovery community centers, public libraries, coffee shops, etc.)
14. Telephone and other electronic communication

Emphasis needs to be placed on service settings that are conducive to building trust, leveling power differentials between peer recovery coach and individual and fostering community access and reinforcement. It is important that the service setting not be physically or conceptually embedded in a clinical environment to avoid the risk of undermining the peer relationship and creating scope of practice issues with treatment and other professional providers.

In some cases, peer recovery coaches are linked to professional or clinical environments, such as treatment or primary care. While these service locations may be key places to initiate the peer service, the actual work ideally takes place in community-grounded spaces that can better serve to nurture the unique peer relationship that is critical to the work, while avoiding clinical connotations. When provided in a clinical setting, there should be a clear distinction between peer and professional services and a dedicated space where the peer services can be delivered.

RCOs offer the ideal organizational service setting from which peer recovery coaches operate. These organizations are “owned and operated” by people in recovery from addiction, along with family members and allies. Further, many RCOs are located in peer-operated recovery community centers. These centers are

15. Vibrant, visible places that showcase recovery as a positive force in the greater community
16. Incubating environments that nurture and develop recovery capital for individuals, families and communities
17. Physical spaces where peer recovery coaches meet with individuals in a safe, power-neutral setting

Because the organized recovery community is the logical and appropriate context from which to develop and operate peer recovery support services (and specifically, peer recovery coaches), certain measures of quality are key. While many RCOs have developed sound organizational infrastructure, others are in need of capacity-building in this area. As peer recovery support services have become an established component of the recovery workforce landscape and part of the recovery continuum, many nascent organizations have added this component to their operations. The development and expansion of this new element in the workforce has called for the need to develop a systemized approach to service delivery with established standards (both organizational and practice), procedures and protocols and expected outcomes. Faces & Voices of Recovery plans to address this issue through the accreditation of qualified organizations. This process is detailed in a later section.

Qualifications and Requirements for Peer Recovery Coach

Because the peer recovery coach is peer-specific in definition and concept, the service role is open to qualified candidates in recovery from addiction. (In some instances and in appropriate contexts, family members may qualify as peers.) Besides meeting the basic requirements for the position (abstinence time, education, orientation and training), peer recovery coaches need to meet ongoing the following requirements in order to effectively practice their craft (continuing education and training, supervision, etc.):

- Minimum time in recovery (1 year)
- Literacy
- Orientation and training
- Continuing training
- Weekly supervision (minimum)
- Background check, when appropriate and as decided upon by the organization

Core Competencies for Peer Recovery Coaches

As in any service role that involves helping others, peer recovery coaches are required to fulfill specific core competencies that qualify them to perform work tasks with confidence and a sense of responsibility. In this context, peer recovery coaches need to have specific knowledge and skills that enable them to develop peer practice in ways that help and do not harm, are ethically sound, elevate to a high level of skill and confidence and are grounded in the authentic process and path of recovery, as determined by the individual served.

REQUIRED KNOWLEDGE AREAS

- Science of addiction and recovery
- Recovery process and various recovery-promoting services and supports
- Practice of recovery values: primacy of recovery, authenticity, participatory, inclusion, self-determination, etc.
- Ethical practice, confidentiality, boundaries and self-care: delivered in non-clinical settings
- Cultural sensitivity and practice
- Trauma and its impact on addiction and recovery
- Community resources

- Agency/organization and delivering peer recovery coaching in an agency/organizational setting

SKILLS

- Engagement
- Motivational enhancement
- Active listening and communication
- Conflict resolution
- Crisis intervention
- Recovery enhancement
- Written communication
- Community liaison and advocacy

From Recovery Plan to Intended Outcomes

The work that the peer recovery coach does with the individual is intended to help him/her define, expand and implement personal recovery options. The main vehicle to help facilitate this is the recovery plan. The recovery plan is individually-driven, initiated in a community context and built upon the person's strengths and assets (recovery capital). The recovery plan reinforces recovery principles such as self-determination, empowerment and individual, family, community and cultural strengths. Following the individual's formulation of his or her recovery goals, the peer recovery coach helps the person map out a recovery plan by which the goals can be realistically achieved on an agreed upon schedule with projected outcomes.

Typically, the recovery plan begins with basic needs that are essential to successful early recovery: food and shelter, followed by stable housing and employment. When this part of the plan is carried out, the individual is more able to articulate and work on higher-tiered goals. The recovery plan can be revisited periodically. As goals are met and achievements mount, the individual can begin to experience recovery as a self-actualized set of investments that positively affect quality of life and support their membership and citizenship in community.

INDIVIDUAL OUTCOME MEASURES

- Days of abstinence per month
- Length of continuous abstinence
- Recovery reengagement following any episodes of drug or alcohol use
- Meeting of basic needs
- Stable housing
- Stable employment
- Educational achievement
- Lack of criminal activity and involvement with criminal justice systems

- Family reunification (when appropriate)
- Access to health and social services
- Quality of life index
- Sense of purpose and meaning in life
- Community connection and social inclusion
- Responsible citizenship
- Successful recovery checkups every

Basis for Peer Recovery Coach Service Rates

See Appendix A for a reimbursement rate schedule for two organizations delivering peer recovery support services.

- Time intervals
- Level of service
- Location
- Modality
- Service unit (individual, family, organization, community)

Peer Recovery Coach Quality Management

- Risk management
- Confidentiality
- Ethical and legal guidelines and consultation
- Supervision
- Peer/client recordkeeping and communication
- Evaluation of services and client outcomes
- Stable pool of staff and peer recovery coaches
- Peer recovery coaches move up “career” ladder or become employable elsewhere
- Sound business and financial practices, including prevention of fraud and waste

VII. Peer-Operated Recovery Community Centers

Peer-operated recovery community centers have been established for the purpose of initiating, nurturing, actualizing and celebrating recovery from addiction for individuals, families and the community. Recovery community centers that are designed and operated by an RCO

18. Function as a hub for peer recovery support services and other recovery supports (such as mutual aid groups)
19. Provide public space for individuals and families to convene in an environment that supports and promotes recovery and recovery-related activities, wellness and prevention

20. Connect the recovery community with addiction treatment, dental, primary health and other systems of care and support

Faces & Voices of Recovery supports positioning the peer-operated recovery community center as a place where peer services are offered and as a service in and of itself, which means that it would be a reimbursable service. This is in direct alignment with SAMHSA's current emphasis on

21. Places in the community that promote both prevention and wellness. Examples from such places include senior centers, Gilda's Clubs for women with breast cancer, drop-in centers for the developmentally disabled, health living groups and family and relationship support groups
22. Peer-operated services as benefits under health reform

Traditional forms of reimbursements are calculated by analyzing units of service that depend on service units. While this may present an uneven fit for recovery community centers, we believe that Medicaid and private payers can and should reimburse for peer-operated recovery community centers. These are places in the community that promote prevention and wellness. Faces & Voices also encourages the development of other sources of funding, including using block grant funding as block grants are repurposed and opened to new types of services with the implementation of health reform.

Value of a Peer-Operated Recovery Community Center

- Offers public space for recovery to flourish in community, promoting visibility and combating stigma
- Serves as a community organizing engine and a vehicle through which the recovery community can respond to challenges and issues of prevention and wellness, substance use and addiction and recovery in the greater community
- Provides a community setting where peer recovery support services are offered and provided in a "one-stop shopping" service menu
- Provides space for recovery classes and workshops, peer training and socialization activities
- Provides a safe space for individuals seeking or newly in recovery to connect with resources, access volunteer and service opportunities and develop friendship networks and community affiliation
- Provides opportunities for civic engagement, leadership development and for the recovery community to interface with the greater community as a key stakeholder
- Offers a safe haven to acclimate vulnerable newcomers reentering the community, post-treatment or incarceration
- Provides a wide range of engagement and commitment levels: from curious individuals in pre-recovery to those in long-term recovery
- Provides an arena for family members and allies to become acquainted with and participate in recovery community culture, services and programs
- Offers infrastructure from which to build culturally-appropriate peer programs and activities
- Offers rental space to and creates links with mutual aid and other community groups

Description of a Peer-Operated Recovery Community Center as a Proposed Service

- Provides service umbrella to monitor individual's recovery plan, accessing a menu of peer recovery support services and outcomes

- Engages and monitors individuals and families in pre-recovery at critical and timely moments of recovery readiness
- Serves as vehicle to route a recovery-seeking individual to treatment or peer recovery support services, as appropriate
- Provides interventions for individuals who clearly need professional, clinical treatment or other health services
- Serves as safe haven for individuals awaiting placement for treatment services
- Serves as space for community members to supervise and act in a prevention capacity to individuals in early recovery who may be vulnerable to relapse
- Addresses crisis intervention before, during and following resumption of alcohol and drug use; routes individual into appropriate service modality
- Provides volunteer and leadership opportunities at escalating responsibility levels for individuals rebuilding their resumes for career positioning
- Provides socialization opportunities and culturally-grounded activities to community members, especially those in early recovery and their families
- Provides family- and community-specific services, programs and activities
- Serves as instrumental and educational resource center by providing food and clothing banks; computers; telephone, email and mailbox services; and information bulletin boards
- Serves as engagement and outreach hub for prevention, outreach and recovery activities

Description of Service Roles Embedded in Peer-Operated Recovery Community Centers

The majority of staff should be individuals in addiction recovery. Various service roles include:

- Administrator – Provides leadership and oversight in policies, programs and operations
- Volunteer coordinator – Recruits, organizes and equips peer workers; matches peer recovery coaches with individuals
- Peer recovery coach – Service roles elaborated upon in previous section
- Peer supervisor – Meets weekly with peer recovery coach to provide support and monitoring
- Programmer – Programs and schedules workshops, activities and meetings
- Front desk coordinator – Welcomes visitors and provides information and referral
- Plant manager – Oversees safe use and upkeep of physical space
- Volunteers – Provide recovery support other than recovery coaching such as transportation and child care

Core Competencies for Peer-Operated Recovery Community Centers

Staff should have knowledge and/or skills in the following areas:

- Risk management
- Plant operations

- Participatory process
- Volunteer engagement
- Scheduling and coordinating
- Active listening and communication
- Ethical practice, boundaries and self-care
- Community resource development
- Community engagement
- Cultural sensitivity
- Liaison and advocacy
- Supervisory skills
- Crisis intervention and management
- Community outreach
- Marketing skills

Service Documentation

- Number of new and frequent visitors
- Duration of individual visits
- Documented access to in-house services and supports
- Number of information requests
- Number of referrals and follow-ups

Peer-Operated Recovery Community Center Quality Management

- Risk management
- Confidentiality
- Ethically and legally intact
- Supervision
- Client record keeping and communication
- Evaluation of services and client outcomes
- Peer/staff stability
- Fraud, waste and abuse
- Business and financial practices

Individual Outcome Measures

- Length of abstinence
- Turnaround time following relapse

- Basic needs met
- Stable housing
- Stable employment
- Educational achievement
- Lack of criminal activity and involvement with criminal justice systems
- Family reunification, when appropriate
- Access to health and social services
- Quality of life index
- Self-determination/self-actualization
- Sense of purpose and meaning in life
- Community connection and social inclusion
- Citizenship

VIII. Authorizing Peer Recovery Support Services

A. Credentialing for Certified Peer/Recovery Specialist

In 2000, Georgia became the first state to establish a certified peer recovery support specialist as a paraprofessional role in its mental health workforce. In 2002, Arizona quickly followed, adding individuals in recovery from substance use to mental health disorders. Since then a majority of states have established peer recovery support specialist roles, as well as systems for certification, primarily for people in mental health recovery. Exceptions include states such as Illinois, North Carolina and New Hampshire that have an addiction recovery component to their systems. Georgia and Texas are among the states where there is consideration for certification for addiction peer recovery support specialists.

As of May 2008, 30 states had developed criteria for the training and deployment of “peer specialists,” while at least 13 states have initiated a Medicaid waiver option that provides reimbursement for peer-delivered mental health services.

B. Developing Accreditation for Recovery Community Organizations Delivering Peer Recovery Support Services

Since RCOs have become an important organizational entity establishing peer-operated recovery community centers from which to deliver peer services, Faces & Voices of Recovery emphasizes the need for organizational accreditation. This emphasis does not preclude or negate the work that has been achieved, particularly in the mental health community, in the realm of certifying peer recovery support specialists. In some cases, it may make sense for the two parallel approaches. In the meantime, the call for accrediting RCOs addresses issues concerning organizations and individual practitioners about risk management, integrity, accountability and quality assurance. An accreditation strategy will help build organizational capacity in RCOs and corresponding networks, establishing a strong infrastructure of recovery support and response embedded in a community context.

Faces & Voices of Recovery will review existing and draft standards to develop accreditation standards. A substantial body of work has already been done in this area. Grantees and other stakeholders in SAMHSA's RCSP came together in 2007-2008 to develop draft organizational and practice standards. These need to be revisited, updated, pilot tested and brought forward for final vetting. Faces & Voices of Recovery is securing resources to undertake such a process that would include bringing together key stakeholders – including those representing funding entities – to finalize standards. Time will be spent reviewing key themes of quality assurance of service and implementation, as well as issues of business and financial practices and fraud, waste and abuse.

IX. Peer Recovery Support Services Organizational and Practice Standards – State of Development

RCSP grantees are community-based organizations providing peer recovery support services that help people initiate and/or sustain recovery from addiction to alcohol and other drugs. They provide linkages to and from other systems including professional treatment, criminal justice, child welfare and employment. Grantees and stakeholders used their best thinking as organizations administering and providing services to draft practice standards that would reflect the recovery orientation and peer-grounded and lived recovery experience of the communities in which services were initiated and delivered.

The resulting draft organizational and practice standards provide a guide for organizations providing peer recovery support services as well as those who administer and finance health and social support systems. They do not cover provider competencies, best practices or the services themselves.

The draft standards are divided into five categories, each with focus areas. Each focus area is broken down into three domains:

- Standards – Operating criteria
- Practices – Activities that build and support the standards
- Indicators – Performance measurements and/or demonstrated levels of quality

Indicators are specified for two levels of performance:

- Sufficient – Adequate to meet the standard
- Proficient – Advanced in meeting the standard

TABLE 3 – STANDARDS (DRAFT)

Five Standards Categories	Focus Areas
1. Organizational Capacity	a. Community strengths and needs assessment b. Program design c. Program implementation d. Program management
2. Peer Leader Development	a. Recruitment b. Screening, selection and orientation c. Peer leader training and development d. Retention

3. Ethical Framework	<ul style="list-style-type: none"> a. Program values b. Empowerment and foundation in strengths c. Stewardship d. Roles e. Boundaries f. Honesty, mutual respect and integrity g. Self-care and wellness h. Inclusion and pathways to recovery i. Peer integrity j. Confidentiality k. Safety
4. Workforce Management	<ul style="list-style-type: none"> a. Workforce policies b. Supervision of peer leaders c. Staff development
5. Organizational Governance	<ul style="list-style-type: none"> a. Boards of Directors and communities of recovery b. Boards of Directors and larger community

X. Evaluation of Peer Recovery Support Services

There is a robust body of research on the value and effectiveness of peer supports for a number of chronic health conditions such as diabetes, cancer, obesity, HIV/AIDS and mental illness. This research has identified the value of services delivered by peers at the community level and the usefulness of a wide variety of social and other supports.

There has been some research on the effectiveness of addiction peer recovery support services. For example, a June 2008 study of Texas drug court participants who received services through Access to Recovery found that “among the specific types of recovery support services, those that were most closely related to the process of recovery such as individual recovery coaching, recovery support group, relapse prevention group and spiritual support group, were more strongly associated with successful outcomes.” In a December 2008 study of the Texas Co-occurring State Incentive Grant Project, it was found that “completers were more likely to receive peer mentoring in combination with other social support services provided by the voucher.”

A study of peer support programs for people with co-occurring psychiatric and substance use disorders found that people who received the services of a “friend’s connector” (peer recovery coach) had dramatically fewer crises and hospitalizations, less alcohol and drug use, improved living circumstances, enhanced income and enhanced health compared to those who did not receive recovery coaching. In another study, the use of recovery coaches to help integrate addiction treatment and child welfare services for parents in substance-involved families enhanced access to treatment and resulted in increased rates of family reunification.

There hasn’t been a cross-site evaluation of the RCSP program. However, there are process evaluations in addition to outcomes measures defined below that report data on service volume and the experience and lessons learned from RCSP grantees. RCSP grantees are required to collect Government Performance and Results Act (GPRA) data from individuals accessing services at baseline (when the client starts

receiving the service) and 6-month follow-up. Results from the program have shown consistent positive results. The most recent collected data from intake to 6-month follow up are below:

- 75 % of clients reporting no substance use, an increase of 19%
- 96 % of clients reported no arrests at 6-month follow-up
- 50% of clients reporting being employed, an increase of 31%
- 52% of clients reporting being housed, an increase of 27%

Mental Health Outcomes

- Clients experiencing serious depression decreased 21%
- Clients experiencing serious anxiety decreased 21%
- Clients experiencing trouble understanding, concentrating, or remembering decreased 26%
- Clients attempting suicide decreased 29

Peer support services are being recognized in a number of health and behavioral health environments. They are also being implemented in criminal justice, adolescent services and HIV/AIDS environments. It is imperative that, as is the case with these other illnesses, a thorough research base on the effectiveness of peer support services be undertaken.

Conclusion

It is clear that there is both a solid need and place for peer supports and peer-operated services in the evolving system construct under health reform. Two significant service roles have emerged from the organized recovery community that fall into these categories: 1) peer recovery coaches and 2) peer-operated recovery community centers. This paper defines and outlines the various service components that qualify these specific service roles in the context that SAMHSA has initiated in response to health reform.

Faces & Voices of Recovery strongly advocates for the accreditation of organizations providing peer recovery support services. An accreditation focus will ensure that both peer practitioners (including peer recovery coaches) and the organizations that house peer services (including peer-operated recovery community centers) are qualified, recovery-oriented and ethically and legally sound. Proposed standards include organizational capacity and governance, peer leadership and workforce development and ethical frameworks. The strategy on accrediting organizations supports the capacity for the organized recovery community to respond to challenges of substance use and addiction, prevention and recovery with community tools in community settings.

Finally, as Faces & Voices of Recovery moves from draft to finalized standards in the accreditation process, two remaining concerns will need to be addressed for both service roles: 1) establishing secure sources of funding and reimbursement and 2) establishing a firm research base that incorporates evidence-based practices.

Sources

- Center for Substance Abuse Treatment (2009). What are peer recovery support services? (HHS Publication (SMA) 09-4454). Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.
- Cloud, W. & Granfield, R. (2008). Conceptualizing recovery capital: Expansion of a theoretical construct. *Substance Use and Misuse*, 43(12), 1971-1986.
- Davidson, L., & Rowe, M (2008). Peer support within criminal justice settings: The role of forensic peer specialists. Delmar, NY: CMHS National GAINS Center.
- Godley, M.D., Godley, S.H., Dennis, M.L., Funk, R.R., & Passetti, L.L. (2002). Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment. *Journal of Substance Abuse Treatment*, 23, 21-32.
- Godley, M.D., Godley, S.H., Dennis, M.L., Funk, R.R., & Passetti, L.L. (2006). The effect of assertive continuing care on continuing care linkage, adherence and abstinence following residential treatment for adolescent substance use disorders. *Addiction*, 102, 81-93.
- Granfield, R. & Cloud, W. (1999). *Coming clean: Overcoming addiction without treatment*. New York: New York University Press.
- Haberle, B., Valentine, P. & White, W. (2009, June 30). Building bridges to long-term recovery: Mutual support groups/peer and other recovery support services/clinical treatment services, their differences and relationship. Teleconference. Washington: Faces & Voices of Recovery. Retrieved September 9, 2010 from http://www.facesandvoicesofrecovery.org/about/trainings_events/2009_teleconference.php#june30
- Klein, A., Canaan, R., & Whitecraft, J. (1998.) Significance of peer social support for dually diagnosed clients: Findings from a pilot study. *Research on Social Work Practice*, 8, 529-551.
- Partners for Recovery, Financing Recovery Support Services. Review and analysis of funding recovery support services and policy recommendations. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.
- Riessman, F. (1965). The "helper" therapy principle. *Social Work* 10 (2): 27–32. Retrieved September 9, 2010 from <http://doi.apa.org/?uid=1966-05594-001>
- Salzer, M. (1997). Best practice guidelines for consumer-delivered services. Chicago, IL, Chestnut Health Systems.
- Salzer, M. (2002). Consumer-delivered services as a best price in mental health care delivery and the development of practice guidelines. *Psychiatric Rehabilitation Skills*. 6(3), 355-383.
- White, W. (2006). Sponsor, recovery coach, addiction counselor: The importance of role clarity and role integrity. Philadelphia, PA: Philadelphia Department of Behavioral Health.
- White, W. (2009). Peer-based addiction recovery support: History, theory, practice and scientific evaluation. Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health.

Appendix A – Sample Reimbursement Rates for Peer Recovery Support Services from Two Organizations

Service Type Description	Billing Code	Modifier	POS	Rate	Per
Organization 1					
Individual peer support office	H0038		11	\$23.73	Per 15 minutes
Individual peer support ind put office	H0038	Hq	99	\$4.00	Per 15 minutes
Peer spt ind out office	H0038		99	\$23.50	Per 15 minutes
Organization 2					
Individual peer support office	H0038		11	\$11.00	Per 15 minutes
Individual peer support ind put office	H0038	Hq	99	\$2.91	Per 15 minutes
Peer spt ind out office	H0038		99	\$11.00	Per 15 minutes