Peers That Count: A Call to Action!

A Peer-Led Peer Recovery Census to Determine Where We Are, What We Contribute, and What We Need

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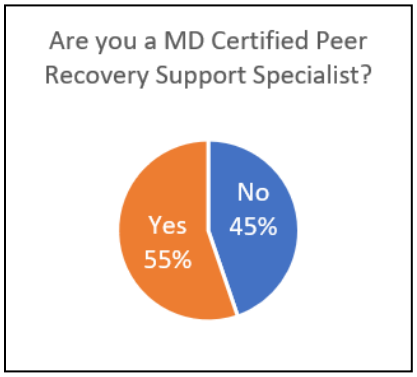
Study Background: Nearly one million Americans have died since 1999 from a drug overdose. Drug use adversely impacts physical, mental, and social determinants of health of those who use drugs and their families. *Peers* are people in long term recovery supporting others who are in or seeking recovery. Although the important role of peers and beneficial effects of their services are well recognized, there is still much to learn about their presence, contributions, needs, challenges, and strengths. *Led by peers,* Peers That Count helps fill a research gap with a count of Maryland peers, and an exploration of *peer perspectives* on important issues impacting peers: service provision, workforce integration, professional development, financial resourcing, social action, and inclusivity.

Study Methods: This is a mixed-method, quantitative and qualitative study using an online survey and four regional focus groups. Survey questions were developed by the research team and further improved by MPAC regional leaders and members. The survey was shared through listservs, social media, email, text, QR code, and in person at peer-related events, and was open for responses for four months between early February and early June 2023. Quantitative data collected included race, gender, education, geographic area, work placement, income and job benefits, professional development and integration, strengths and challenges within the workforce, and opinions on Medicaid billable services. Data was analyzed by determining frequency and percentages of responses. Focus group members gave important statements that offered greater depth to survey responses. Data was analyzed to identify major themes. Qualitative and quantitative data were then integrated and are presented below.

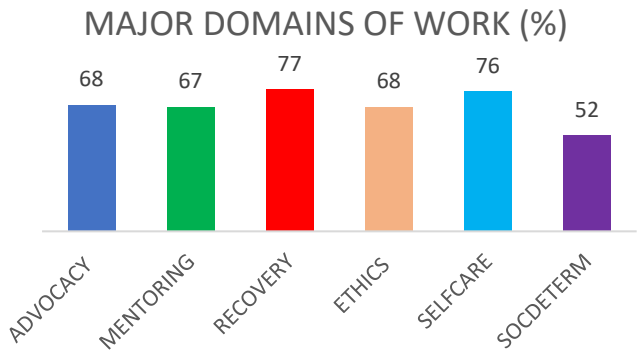
Study Results: Characteristics of Peer Participants:



A total of 465 peers participated in the Peers that Count survey, 21 of whom also participated in regional focus groups. About a third of all participants were from Baltimore City (35%), and about a quarter were from the Central Region (28%), with similar proportions from Western (14%) and Southern (14%) regions, and about 9% from the Eastern Region. About 46% of all participants were White, 35% were Black or African American, about one in ten identified as of mixed racial ancestry (11%), and about 8% did not provide information. One in twenty participants identified as Hispanic or Latino/a/x (5%). Over half of all participants were women (56%), a third were men (33%), there were 2% who identified as transgender, nonbinary or genderqueer, and 9% preferred not provide information. Regarding sexual orientation, most identified as heterosexual/straight (71%), a significant number identified as LGBTQ+ (17%), and about 12% preferred not to respond. As for formal educational attainment, 22% had attended some high school (H.S.) or had a H.S. diploma or GED; 40% had some college education; 13% had an Associates degree; 15% had a Bachelors degree; and 10% had a Masters or doctoral degree. There were 55% certified as Maryland Peer Recovery Support Specialists and 45% of participants were not certified.

Study Results: Peer Work Settings and Roles

A large majority of peers provided direct recovery services (86%), although some of them also served in program administration or coordination (8%). A smaller proportion served as lead peer staff (3%) or peer supervisor (3%). Almost nine of ten reported their job duties were relevant to the peer role (88%).



The figure to the left presents the percentages of peers who "strongly agreed" that their work involved the domains listed. Of note is that only about half of the peers strongly agreed that their work involved addressing Social Determinants of Health (which include food, housing, employment, and education).

Qualitative Theme: Peers Serve in Diverse Settings With a Wide Range of Roles

"I would define (peers) as the first line for help."

Peers represent inclusivity, serving, "anybody walking in seeking services in our building."

Peer study participants served within varied settings, including public County health departments, drug courts and jails, as well as nonprofit organizations including crisis centers and recovery houses. Roles played by peers were extremely diverse, representing supports for behavioral health and social determinants of health, and within substance use and mental health, such as group facilitation and housing assistance for those experiencing homelessness. Harm reduction was a key approach, including through Narcan trainings and work done in support for medications for opioid use disorder. Peers were also involved in clinical treatment including detox and stabilization. Populations served across settings were similarly broad, including transitional-aged youth, gender-specific services for women, and work with gang-involved individuals. The dual identity of peers as people in long-term recovery and as workers supporting others in their own recovery was represented by one respondent, who highlighted peers' utilization of the Recovery Capital Index for both self-assessment and measuring the well-being and progress of those served.

Study Results: What is Peer Recovery Support?

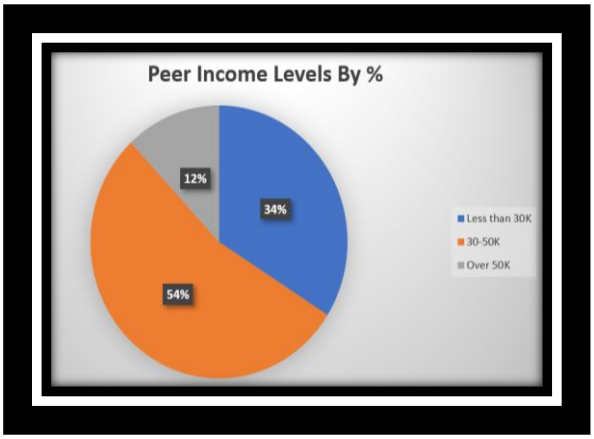
<u>Qualitative Theme</u>

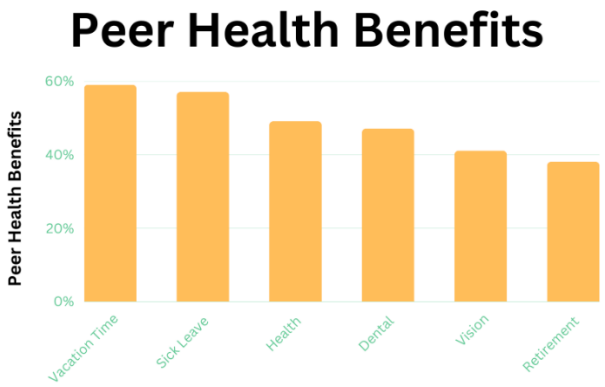
A "lived experience to a lived experience" that goes "deeper than empathy"

Participants described their work as meeting people where they are, without judgment or condemnation. The peer role is non-clinical. For example, while a clinician may schedule time-limited 50-minute sessions, a peer can spend hours with someone. One peer stated that, "we can meet somebody wherever. We can go to their home, meet them at McDonalds, you know, wherever. We can walk down the street with them." Peers described a trusting and organic relationship in which individuals are supported to find their personal agency while navigating transitions, including through personal traumas and systemic barriers. Peers are able to form tight bonds with individuals served while also supporting the development of other important relationships through coaching, community networking, resource brokering, and advocacy.

Study Results: Supports and Resources for Peers

About a third of all peers' annual income was less than $30,000 (34%). An additional 54% of peers made between $30,000 and $50,000 annually. Only 12% made more than $50,000 annually. This reflects a low pay scale as the annualized full-time minimum wage salary for one person in Maryland is $27,560, and it may be assumed that numerous peers have families and financially dependent children. More than half of peers felt uncomfortable with their wage (56%). In this context, it is not surprising that about half of peer respondents had two or more jobs in this role (52%) and that a third had to move because the wages they made were not enough to stay in their communities. Of concern is that about five percent of peers do not have health insurance from anywhere, job or otherwise. The tables below depict annual income and the percent of peers who receive each kind of benefits in their jobs, with vacation time and sick leave time being the most frequent (59% and 57%, respectively). Only 38% of peers received job-based retirement benefits. Most peers' current positions are grant funded (60%).





Regarding professional development, a great majority agreed strongly (59%) or somewhat (24%) that they received access to ongoing relevant training opportunities. Identified training gaps included technology, leadership development, and role-specific workshops relevant to particular peer settings (i.e., at hospitals, jails, schools).

Qualitative Theme: Investment in Peers is Variable – Overall, More Support and Resources are Needed

Some peers felt greatly supported and invested in, including by supervisors, health officers, and boards of directors. Peers valued relationships from supervisors who were aware of their lived experience and remained trusting and nonjudgmental. One peer said there was, "nothing we're lacking except more peers." In terms of pay, public sector jobs were more likely to offer set pay scale raises and there was variability in compensation based on setting, job function, and geographical region, among other factors.

Although some respondents felt well supported, there were numerous others who did not, and there was an overall disheartening sentiment that more resources were needed. A lack of support was attributed to lack of clear roles, lack of understanding of the peer role, and systemic barriers including bias and stigma. For greater support and resourcing, peers felt a shift was needed to respecting peers for their, "lived experience and lived expertise." Though there are professional development opportunities, much is driven by peers through provision of peer-to-peer support, when it should also come from the system.

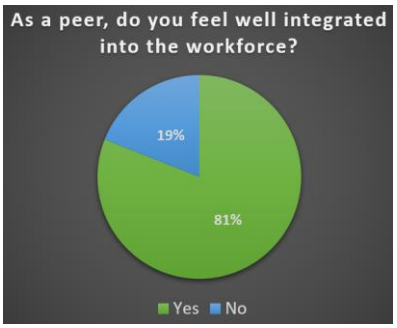
With low pay and lack of benefits alongside a sense of being undervalued generally, one peer expressed, "I don't feel verbally and financially compensated." Peers expressed that once certified, beyond the peer supervisor role, there is a ceiling for advancement and a need for higher job levels as well as support for acquisition of college level degrees. Job security is often lacking based on short grant cycles and administrative turnover.

One important support that respondents identified as lacking was assistance for peers' mental health and well-being. The work, they stated, could be isolating and because of the deep empathy felt, quite triggering of their own lived experience. Although their non-clinical boundaries were cited as a benefit, they also could come at a cost with such close connections forged then some clients overdosing, and some dying.

"I've been where a lot of these people are currently. So it's hard not to take myself back to that place"

"We have support groups for people we work with, but where are the support groups really for us?"

Study results: Peer Workforce Integration



Quantitative survey results indicated that about four out of five peers felt well integrated into the workforce (81%). Focus group data indicated that some peers felt like respected and trusted team members at work, and valued resources within their communities. Examples of this trust were being given office keys and use of the company car. Peers felt like an important part of the continuum of care, and that they not only supported each other with mutual empowerment, but felt respected by clinicians and other colleagues. Being positively integrated into the workforce for one peer looked like this: "to be comfortable enough to ask for what's needed."

Qualitative Theme: Growing Respect for Peers but Significant Misunderstanding and Stigma Remain

Alongside such positive experiences, peers elaborated extensively on barriers to workforce integration, with stigma and unfair treatment being major ones. For peers from racial and ethnic minority groups, there was a sense that cultural bias contributed to stigma. Peers expressed that some people also stigmatize them based on their history of using drugs, without recognizing their great value. Peer opinions, perspectives, and skillsets often get overlooked and under-valued, which is frustrating and can be a trigger since clients may suffer as a result of underutilizing peers' lived experience and expertise.

They're still looking at us like *those people*. 'You're going to hire an addict to help an addict? It's like the blind leading the blind.' But if you really look into the success of peers and you learned about it, I can't imagine anybody not being on board with it.

One peer expressed that a lack of university degrees is a barrier to their ideas being as valued, and that, "there are jobs we'd be well equipped to do but we don't have a piece of paper." Stigma and lack of degrees contribute to employers' decision-makers not being peers. At the entry level, peers may be given non-peer roles, doing administrative and personal assistant tasks without clear peer titles or roles. If this may be more likely to occur at larger treatment facilities, peers at grassroots recovery centers face a lack of financial resources to offer ample support for individuals' social determinants of health. A lack of understanding of the peer role shows up in other ways, including host organizations lacking a clear plan for peer integration, and peers wondering whether administrators at policy-making agencies truly understand peers' needs. Peers did not want to be seen as a quick fix to organizational or sector-wide problems, or simply a way to support a grant or new funding streams. Peer commodification in this and other ways was also a concern, with one respondent explaining there was a history of peers replacing more expensive job roles, like recovery counselors, because peers were cheaper. This may contribute to inter-profession tensions and distrust felt by peers toward system decision and policy makers.

To address these barriers, numerous ideas were expressed. To prevent stigma, one respondent recommended mandatory agency training, including for greater understanding of the peer role and greater appreciation for cultural diversity. More training and support for peers, "to make sure they have the knowledge they need," was also a key strategy. Allowing peers to stay within their scope and approach was also stressed, not combining the clinical with the peer role. More resources are also needed for recovery organizations to support peers meeting the extensive needs of those being served. And within a landscape of under-resourced organizations competing for limited resources, the need for greater collaboration and working more closely was also an expressed need.

Study Results: New Medicaid Policy for Reimbursable Peer Services

Starting in summer 2023, certain treatment providers will be able to bill Medicaid for substance use recovery services. State grants will continue to fund other peers. Two thirds of peers in this study were aware of this policy (66%). A majority believed Medicaid billing for peers will be beneficial (50% strongly agree, 22% somewhat agree), though one in ten peers disagreed that the policy will be beneficial (6% strongly disagree, 4% somewhat disagree), and 18% neither agreed nor disagreed. The potential benefits and challenges that peers anticipated are represented in the tables below.

Potential Benefits of New Policy	
Better salaries	70%
More recognition	69%
More jobs	65%
Training	60%

Potential Challenges of New Policy	
Bureaucratic barriers	59%
Wage differences	52%
Certification	31%
Enacting the new policy	29%

Qualitative Theme: More Preparation is Needed for Peers to Navigate Medicaid Reimbursable Services

Peer respondents felt there were many unanswered questions about the new Medicaid billable policy for peer services. Peers reported a lack of clear information and some misinformation on policy content and projected impact. More training, attendance at info sessions, and proactive outreach to ask questions was still needed to clarify details, like what documentation will be required. Since peers will be most affected, targeted outreach to this group was needed, but there was a feeling that treatment organizations were instead receiving the bulk of information. This lack of clarity on how the policy would positively or negatively impact peers created uneasiness about lack of preparation, and questions around transparency.

"I pray that the peers don't get pushed out in front and not given the tools that they need to properly provide the services."

There was some skepticism around how or even if additional funds flowing into provider organizations would benefit peers, with one respondent questioning, "even if it's a trickle-down theory, what's the trickle-down of that theory?" Peers did not want to be thrown into something unprepared based on organizations' rush to access new funding. Peers expressed concern this could lead to exploitation by institutions desiring the revenue but without true commitment to peer work. One peer stated, "nobody wants to feel like a pawn in the game." Even with these concerns, there was some recognition of the benefits the policy could provide, with one peer stating that more advocacy is needed so peers at other settings besides those initially eligible could benefit.

Study Conclusion and Implications: Peers that Count is an important, peer-led study with a large and diverse sample, using mixed methods, covering a broad array of topics, and with important practice, policy and research implications. The following represent some of the main calls to action generated by study results, with MPAC peer leaders convening to strategize around how their advocacy, education, and leadership development may be informed by study results.

1. To develop and sustain the peer workforce, ongoing efforts are needed to reduce stigma, increase compensation, and facilitate upward mobility through new peer management positions and connections to degree programs in allied health professions.

2. As peers are increasingly asked to support individuals' social determinants of health (food, housing, etc.), more training and resources to provide this are needed.

3. Future research can build on this study by examining why some peers get certified and some stay uncertified, using this data set to explore differences across regions (including peer compensation, training opportunities and workforce integration), and seeing how the new Medicaid reimbursable policy is playing out.