MAUREEN FITZGERALD: Addiction technology transfer center. My name is Maureen Fitzgerald. I'll be moderating the session today. And our webinar producer is Veronica Wang. Our presenters today are Dr. Christine Chasek and Dr. Michael Flaherty. The topic is Workforce Recruitment and Retention-- Strategies for Rural Areas and Recruiting and Retaining Peer Support Workers.

The Great Lakes ATTC is one of 10 US-based regional and six international HIV ATTC centers. We cover six states in the Midwest-- Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin. We are funded by the Substance Abuse and Mental Health Services Administration. This year the ATTC network as a whole is celebrating its 25 years of supporting the addiction treatment and recovery services field.

Couple of housekeeping things to [AUDIO OUT] your speakers, so please make sure that they're turned on and up. There's no call in number for today's webinar. But please use the chat and questions feature throughout the webinar to ask questions or add comments. We will have a Q&A session after the presentation.

Now I'd like to turn webinar over to Dr. Michael Hoagie.

MICHAEL HOAGIE: Good morning or good afternoon, everyone. Thank you for joining us today. My name is Michael Hoagie. And I've been coordinating this webinar series on recruitment and retention. This is the third in a series of three webinars. We began with an overview of recruitment and retention in our first webinar and had a demonstration of the careers of substance website in innovative workforce-related website pioneered by the Department of Public Health in the state of Massachusetts.

In our last webinar, we focused on recruitment and retention strategies and paid special attention to the recruitment and retention of persons of color. And on today's webinar, we'll be focused on recruitment and retention in rural and underserved areas and the recruitment of retention of peers and recovery coaches. All of the webinars have been or will be recorded and online and available, so if you've missed any of the previous ones or would like to access this one, you'll be able to do that through the ATTC website.

I'd like to introduce the two speakers for today, Dr. Christine Chasek will begin by talking about recruitment or retention in rural and underserved areas. She's an associate professor at the University of Nebraska in Kearney and the Department of Counseling in School Psychology.

She is director in Kearney of the Behavioral Health Care Center of Nebraska. She is a practicing mental health and addictions counselor. She's chairman of the Nebraska Alcohol and Drug Licensing Board and President-elect of the International Association for Addiction and Offender Counseling, so she brings lots of experience-- relevant experience to today's topic.

Also joining us, colleague and good friend of mine, Michael Flaherty, who will be talking about the recruitment and retention of peers and recovery coaches. He's a clinical psychologist who's been practicing for 36 years. In 1999, he founded the Institute for Research, Education and Training in the Addictions, better known as IRETA, which is located in Pittsburgh. He has authored 20 federal and foundation grants that were funded and approximately 50 articles, chapters, and monographs related largely to addiction counseling.

He's a pioneering leader in building a science of recovery, and over the past 10 years, he has spoken in 45 states on recovery-focused care. He's been an invited advisor at the White House Office of National Drug Control on multiple occasions and served most recently on its national heroin task force for overdose prevention and helped develop the first national plan to address the opioid epidemic in the United States. And he's a retired captain in the US Naval Reserve.

I'm going to start at this point in time by turning it over to Dr. Chasek to talk about recruitment and retention in rural and underserved areas. Dr. Chasek.

CHRISTINE CHASEK: Thanks, Michael. Appreciate the nice introduction and the opportunity to present here. So you'll see there my slides up on the screen. And all those things that you just talked about me, that's a repeat there. So what I really wanted to start off with is tell you a little bit about where I come from so you understand the context and how this fits into rural recruitment of the addiction counseling workforce, but also we address the larger workforce as well.

So back in 2004 in the state of Nebraska, the legislature created a behavioral health care workforce center, and we call that BEACON, the acronym there. And they created it because at that time prior to that they had de-institutionalized a lot of the behavioral health care in Nebraska. And so they were switching resources from larger state hospitals into more community care.

And what they realized rather quickly was that they didn't have enough workforce in those areas where there's community care to meet the demand. And so they put some resources

into a recruitment and retaining effort through-- actually it was-- it's housed in our medical center at the University of Nebraska Medical Center. And, of course, that is located in our largest city, which has a very urban focus.

And it's always curious to me because I come from a rural focus when we have meetings and such. And we discuss these issues, it's very clear that most of my colleagues have a very different lens that they look through the issues with, coming from lots of resources and specializations and being able to utilize multiple types of people in the workforce. And those of you in the rural areas know that we just don't have that. We have a workforce that is very diverse in terms of their skills. They're asked to do many things.

So that's where we started. That's where I work and where I come from at this. I am the addiction specialist in our health care center as well. And so I think that I appreciate the invitation to talk about that particular part of our workforce retention in Nebraska.

And as-- if you don't know Nebraska, Nebraska is a very small state in terms of population. It-- when you look at our makeup geography, we only have two areas in Nebraska that are considered urban, which is Omaha and Lincoln. The rest of the state is considered rural. And that is my charge is to try to get workforce into these rural areas.

And so I am located in a university that's in the middle of Nebraska, the town where the university is has about 20,000 people in it. I happen to come from a more even urban-- or sorry-- more rural part of the state, which is actually frontier. So that's smaller than rural and out in the panhandle.

And so it becomes a real challenge for us to recruit and retain our behavioral health care workforce mainly because when we get people interested, they go to training programs which are located in our urban areas, and then they tend to want to stay and not go back to their rural roots. Or the people who are trained in the urban areas are not willing to relocate and go into the rural areas. So we've had to get real creative on how we recruit and retain the workforce.

We started with at BEACON a residency program for psychiatrists. That was really the focus that they had in recruiting was they wanted more psychiatrist. And to help you understand in Nebraska, we-- 88 of our 93 counties are considered underserved for behavioral health care providers, and that's all spectrums. When we look at addiction specialists or counselors, that's even worse. So I would say probably 90 out of the 93 are considered underserved for

addiction services.

And so what we tried to do to begin with is do what we call an ambassador program. So an ambassador program is building the pipeline, and it starts really, really early. It starts at the high school level.

So our center sponsored these ambassador programs where we would get high school students to come to some of the larger towns to Nebraska to learn about what behavioral health care professions are. And this was wildly successful. We have at this point hosted over about 300 high school students from 52 rural counties. And 81% of those have went on to enroll in a college.

But as you can probably tell-- and I know many of you are working in agencies and such that want to hire people-- when I talk high school, that's a long way off from where I need them to be in terms of hiring. And so it's a slow process with this ambassador program. But once it's gotten established now, kids are getting introduced to the carers and the different kinds of behavioral health care professions, and they're starting to understand what it would take in order to move on to get into that career.

Most career classes in high schools focus on medical only in the sense that they're looking at nurses and doctors. Many of the kids don't know what a licensed behavioral health care professional does, and they really don't know what a licensed addiction counselor does or what's the difference or what does the day look like, what training do I need. And so it's really has started at that lower level for us.

Now that we've got that established, we've actually been able to hand that program over to other types of organizations that are competing for funds to run that. So groups like we have health care, AHEC, they're called. They're health care centers that work with the high schools and high schools. The Department of Education has been doing some of these things. So now we've been able to move on into a higher level type educational system for our pipeline development.

So the other thing you see there on my slides is sponsored internships. So what we're doing with that is we have actually been able to secure funds through grants, through some of our legislative dollars, and just being really creative through finding some other funding sources to do some sponsored internships. And what that means is the students who are finishing up a

master's program or a bachelor's level program in addiction counseling can apply to our center to be placed in an internship where they get paid.

Now the thing that's really great is that the students then-- we recruit agencies and other providers to be our internship sites. So it's a win-win. The agencies get some workforce and they get some trained people to come in and work for them in an internship and they can do a test run. Would this person be a good fit for our staff? And the student then also gets to experience an internship maybe outside of their community, a more rural kind of internship. And they get paid.

And so granted it's not always a lot of money. We have varying pools of resources, which I'm going to share with you in a minute, but they are able then to get that experience in those rural communities and in different levels of agencies. And typically when they're placed in those internships, that turns into a job. And so that's really been another kind of I think success story that we've had of sponsored internships.

Then the other thing that we do at BEACON to develop this recruiting and retaining of the workforce is we have agreements with all of the training programs across our state. And so at the very beginning that didn't happen. At the very beginning, they were only working within the Med Center. So the Med Center was having agreements with the psychiatry department or maybe the nursing department. And then we had a clinical psychology department, but that wasn't helping our rural folks because all of those people were urban.

And so they-- when I was brought on in the rural area, we started talking about all of the other training programs across our state that were training licensed behavioral health providers and licensed addiction counselors. They weren't included in any of these efforts, and that was a real loss because we were missing out on the majority of the workforce in the majority where they get trained. And so we had to be creative with expanding our scope of who does these services.

And the neat thing has been with working with the training programs. We will get a student interested and plugged in who maybe is going to do-- be a licensed clinical social worker, and we start exposing them to the addiction counseling area and helping them then get their license to be an addiction counselor. And then that expands, again, the workforce. They can do more of those services in the rural communities. So that's been a real success.

And then the last thing they're training of existing workforce. We do focus a little bit on that,

which-- that's really on the retention side. So we offer trainings on compassion fatigue, burnout, trauma-informed care, all other kinds of trainings, CEU opportunities, we do lots of webinars like this for folks in the rural area that can't travel to certain places to the more urban areas to get their CEUs. So that's been something that we also offer.

So in terms of funding, like I said, we do have many different pools of money from different sources. The legislature is not too happy to give out a whole bunch of money. And as those dollars dried up, then we've started to diversify. And I want to just quickly run through a couple of these that are applicable to the addiction counseling workforce.

So the first one here is HRSA, which is the Health Resources and Service Administration. We have a grant right now that is the Behavioral Workforce Education Training grant-- and that grant it's a little over $1 million-- is targeted at recruiting and training addiction counseling professionals and community health workers, which in our state is a lot like the peer recovery coaches. And so those two programs, we got dollars to actually recruit and put people through their educational process. About 80% of those dollars go directly to students.

And so currently we have-- we're able to take 35 students a year for five years and train them to get their addiction counseling license. So in the state of Nebraska, we have a license. And so they are able then-- we can put them through all the education. Now we switch over, and we go into this AmeriCorps grant when they get up to the internship portion.

And we can pay them through that sponsored internship through an AmeriCorps grant to do the service. So we have host sites all over the state of Nebraska to place them into behavioral health agencies to get their training. So that's the AmeriCorps grant.

So those two things go hand in hand. And I will tell you that's been super successful because we've had a great response on the addiction counseling side. And we-- the students-- we're about halfway through our first year. We've had some really good success stories. They've started their training, and they're working in their communities-- in their rural communities being able to provide addiction counseling services.

And most of the training programs we have are a combination of online and face to face, so we're able to blend that and get them to the training sites. We do have a little bit of SAMHSA funding for some grants. But the USDA, this was an area that was a creative find for us in terms of rural.

So because our state is such an agricultural state, the USDA funds many things. And I didn't realize in particular that they funded behavioral health and addiction counseling stuff. But with the opioid crisis-- and it was great to hear that Dr. Michael Flaherty was a part of some of that funding. That's awesome getting that going-- we have applied for a couple of USDA grants on the opioid side to help support that prevention and the workforce that are out doing some of that work in the rural areas.

And what we found in terms of that piece is a lot of our rural folks don't really understand opioids. And they have problems, but they think it's prescription drugs. And so they don't understand why they're having such an issue. And so we've been able to do some creative things with that funding and getting our people who have internship, some of our workforce, paid to do some of those services that way. And then we also have a little bit of university-based funding in as well.

Now I say this-- and I know most of the people on the webinar here are not university folks or folks who are really into heavy academic grants and training-- but I say this because I was a agency director for many years before I got into higher education and started teaching. And I was struggling with how do I hire my providers? Where do I find them?

We would do the traditional put an ad in the paper and do the word of mouth stuff. And we never really connected with our university. And in Kearney here, it's right in town. And so I had that experience on that side. Now coming over to the academic side, the academics are really interested in getting students and also doing grants.

And so if the two can come together, I would say that's a good resource for providers to connect with your academic centers and your training programs and see what they're doing and what help they need because every academic program needs grants and needs grant funding. And so-- and what they really, really need is providers out there that they can go into and be able to work with to provide some of those clinical services in the resources that they need for these grants. And so it would be a perfect marriage, and I would really encourage the people in agencies to look into that particular avenue for recruitment.

The other thing is they have a lot of students who need experiences. And if you get a student do the internship, you can let them before you hire. And so that is-- that's just a win-win there.

So in terms of-- with my remaining time-- lessons learned here, I wouldn't say the things that we did not do well in the beginning with our efforts here on recruiting and retaining was did not

involve everybody to come to the table. We did not involve addiction counseling. We did not involve behavioral health. We did not involve the training programs. It was a very limited scope. And we just never made any headway.

So once we got involved-- the training programs involved, actually our licensed workforce in the state of Nebraska is up by about 17%. And so it really started helping when we did-- involved-- brought more people to the table and to be inclusive. So when we started our rural outreach, it actually started at a provider level.

So my predecessor was a somebody in a provider role, and they just didn't have the time and resources to do the things that I've been sharing with you because it was more of an academic thing that needed to happen. And so when we switched over to an academic, then we were able to make some headway because that's what academics are supposed to be doing. And they could spend the time there then connect with the providers to get the workforce out and into the agencies.

The other thing I would say for us in terms of rural is targeting rural medical providers. And what I mean by that is our internship sites, we have gotten really creative with where we put our interns. And typically they don't have a standalone addiction counseling shops or behavioral health care counseling providers. A lot of times the rural folks are going to their medical providers to get their services.

And so we have partnered with them to place interns into medical clinics-- rural medical clinics, and then they're able to provide those behavioral health services with some supervision. And there's less stigma for that rural folks to go into their doctor, and they're now getting the right services. We have a long ways to go with that whole integrated care idea, but it is something that has really been successful in terms of again making those partnerships.

And I would say I just want to leave with the idea that really that partnership, if you're in addiction counseling agency and you need some workforce, go find those training programs that are training addiction counselors and see what you can do to collaborate-- universities, colleges. I know in our state also we have some provider organizations that provide some of the training. Your associations, those kinds of things, they can be great resources on recruitment and building the pipeline.

And lastly the thing that we did in Nebraska to connect everybody was we created behavioral health care jobs website link. So what we found is that students didn't know where to go to find

jobs. Providers were just using traditional networks for recruiting, but there was nothing specific.

And so we created this Nebraska Behavioral Health jobs website where for free agency providers can put on their postings for openings. And all of the students and the training programs I talked about, one of the things that we do is we mandate that all students get registered on this job website. So you can see the pool of people, look at resumes, and they recruit from there. So that's another helpful thing we can use in terms of recruiting the workforce.

So that is all I have for now. I'll be looking forward to your questions at the end. And I am going to now turn it over to Dr. Michael Flaherty, and he's going to tell us all about peers and recovery coaches. So, Michael.

MICHAEL FLAHERTY: Thank you, Dr. Chasek. Good afternoon or good morning to all my colleagues. I'm very thrilled to be here today with so many of you across the country and talk about what I think is the future 21st century workforce and that would be, of course, peers, particularly in the recruitment and retention of peers. As we face this dilemma in our country of what to do with the growing numbers of people who are outside of treatment, peers become more and more identified in every community-- locally, statewide, nationally-- as one major resource that can be developed and have been developed for some time to reduce that gap between those outside of our formal agencies and those in the community needing treatment.

And the roles and the variety of peers as I hope to cover with you seems almost endless at this time. But the effectiveness of them as I'll close with is certainly being established. So just anxious to talk about this wonderful group of potential workers and new workers.

So what is a peer? What is the basic definition? I have a SAMHSA definition on your screen. I personally like William White's definition, which is one sentence. It is healing provided by a wounded healer themselves. And that to me seems to capture it in one sentence.

But SAMHSA has the definition of peers who are successful in recovery themselves and who are now experiencing that help and giving it to others to shared understanding, respect, and mutual empowerment. They help people become and stay engaged in the recovery process and reduce the likelihood of relapse. They can be effectively extend the reach of treatment itself or a clinical setting where they can just be involved in sustaining recovery or helping

people get to that treatment. And more and more you're going to find that peers are being used in the trenches such as with first responders and in particular situations that were never even thought of. The citation is below, and you can just link on that and get that citation should you want to know more about the basic definition of peers.

They are fundamentally experiential. They speak not from academic training as much as from their experience that they bring to the person into the situation in which they are. And for that reason, you have to be somewhat understanding of them.

They have limits-- they real limits. They should have sustained recovery. They should not be put into too many high pressure situations where that recovery would be threatened or unsupervised or in some ways just not respected.

However, a peer worker is credentialed first by that personal experience that they bring. And this goes back centuries, not just to this era of trying to close a workforce gap where we have more workers to address the problems and mental health and substances . But to look at that experience itself in recovery, they provide others similar challenges. They know how to connect people to the resources available. But fundamentally they are experientially covered.

And the definition as I go through, I wanted to point out that as they evolve now, those that are called specialists are generally peer specialists or certified or licensed individuals. The word specialist seems to be a word being restricted now to those who have received the state certification or license as a peer specialist.

A peer is not serving per se as a counselor or social worker, case worker, psychologist, judge, lawyer, police officer, roommate, or best friend. They may also be some of those things, but the role is that of a peer. It is experience of mental health or substance use or family coming to the individual and not in those other roles. It is not a sponsor, someone necessarily associated to a fellowship because those fellowships themselves have the wrong guidelines and roles for sponsors.

And that may, in fact, be the case that a peer may be a sponsor to others, but it is not such-- a peer is distinct of fellowship. A priest or member of clergy as such, again, it's not a person serving as a member of clergy in that role although they may also be that if they're coming from their personal experience of substance use or mental health or related issues. That's what they are serving as in that moment.

And replacement for formal counseling certainly that has often been perceived erroneously. It is not. It is to support that. It does not replace treatment, and it is not a cheaper alternative to treatment. Fact, it's a strengthening to treatment. And every study that has examined the role of peers in a community has shown that the long-term and ongoing effect is just that, an improvement of the local treatment.

In here I have a reference at the bottom that would encourage you one of the best recovery guide manuals I've personally ever have seen is from an agency called Focus on Friends in Findlay, Ohio, and I believe Ellyn Schmiesing is on our call today. But if you reach out to Ellyn, I'm sure she'll be happy to forward that to you, or there is a link to it in the system. Wonderful guide there is prepared with all the steps [AUDIO OUT] the philosophy and the reality of being a peer in their community.

I particularly like this one definition of peer. I think it captured it for me in addition to William White's who also said that a peer is an amends made in action where two people get together and make amends. That's, of course, joining fellowship with peers. But this particular quote by a person in early recovery-- "I'd like for you to extend your hand across to me not down to me. In the warmth of your class by one to sense, you're saying as one human being to another, we are in this together. We are joined in problems not in one form or another that continue to pester me, too. When this happens. You have come alive as a person. Then I'll be in a lot better mood to listen to what you have to offer."

And that's simply the role of a peer that is unique to that being a peer. Many of our institutional-based professions cannot leave the institution, cannot leave the office, cannot reach into the population where the need is greatest. And peers can do that, and they can do it just by doing this very slide. Getting out of the confines of an office.

Recruiting peers is really not that much of a challenge. It's really more of a challenge of finding a high enough number of peers. But peers are best recruited when you're looking at the population that you want to serve and then saying who from that population already has experienced mental health or substance use issues or family-related issues to mental health substance use or whatever the unique population is you're trying to reach.

And you can look at William White's classic book, which is referenced in the last slide of the presentation today on peer-based addiction recovery supports. He notes that all of the peer kinds of groups that existed at one time or another, even one for lion tamers. So some of

these are no longer in existence, but there are hundreds of them over the years that brought peers into our efforts to address health care in general and mental health and substance use.

Here we're looking at age, gender, ethnicity, sexual orientation, prison experience, a peer who's gone through prison and now is in recovery, family experience is a big one with the overdose population, finding family members who experienced and survived overdose or experienced and sadly not survived overdose in their family, veterans, again, speaking to Hancock County and the great effort that I mentioned Ellyn Schmiesing and doing there with the battle buddies group of peers reaching out to veterans who are in our community coming home from combat situations with PTSD and other disorders including substance use. And each of these have their own guidelines. They designed them to do what works for them. It's like a personally-tailored glove to the situation rather than a cookie cutter or signs down kind of approach.

What constitute a peer is defined by each individual. This is unique also rather than by the organization. Certainly the peer will hire or the organization will be hiring a peer based on credentials and what they need. However, the definition of who is a peer is still held by the individual. They are a peer in recovery in what general population.

A peer may be agency employed or volunteer. Actually the majority today, about 80%, are volunteer. In many cases, they're standing up and reaching into the community, and every community that is addressing overdoses in America is finding that as a high volunteer army of peers is one of the most successful ingredients. So, again, it's just something the workforce for today and tomorrow.

Prior to getting into the hiring and working with peers in your agency, you want to make sure that the leadership and integration of the peer staff is-- in discussion and support through top down and down to top. Here I have cited two links that I think they're just wonderful kits of agencies that have done this. The Philadelphia model, with their tool kit, is the first link, and the second one is a SAMHSA Behavioral Workforce Recruitment Retention Tool.

Each of these tools have step-by-step guides. So in your community whether they be rural or urban in whatever population, I highly recommend you get one or both of these guides. It would save you an enormous amount of time going through what you need to do to get involved in peer development, also your state regulations, which I'll talk about.

Identify as a peer support champion in your agency. And when you have that person,

somebody who will advocate and understand what you may be going into with peers, protecting them, having them involved in all decisions, you want to try to hire more than one so they aren't seeing or felt as an isolated member but in fact, have some back up in the ranks at the agency. Recruitment of peers, continuing solicit perspectives of people recovering when you're setting up your agency to bring peers into the workforce. There's a number of issues-- supervision, clinical, ethical-- decisions that have to be made, roles. Are they going to be part of the agency.

I've seen so many variations of roles and agencies somewhere in the actual staff-- clinical staff meeting. Some are not. Some are just dedicated to aftercare programs.

But, again, you want to define very clearly so that people are being recruited and know exactly what you expected them to do be sure that the peer you recruit has a desire to work directly with clients, and that's a key word, client. That means, of course, that somebody is being paid, and somebody is been tending to the needs of the responsibility of someone in an agency, a client that you would not call somebody in a class a coffee table a client on your own, but you would if you're doing it for an agency.

So is the peer OK with that? Are they comfortable with getting paid to do that kind of work? Address the concerns of your existing staff. Are they threatened? Are they going to be threatened? How will they work with counselors and treatment plans? How will recovery plans come into treatment plans? These are things that peers that.

Clearly define staff member roles with before integration. So you have that clarify expectations and limits on peers and ensure that you have a supportive regular environment with clinical supervision, one of the real retention factors, which I'll talk about now.

In retaining your peers once you get them-- and if you're lucky enough, you can get enough of them. And what we're finding across the country in developing peers is that once they become self-identified as wanting to be a peer and they have sustained recovery, let's say two years or more, and they are now into wanting to help others, keeping your peers involved, and they absolutely want to be educated.

So reaching some core competencies, giving them skills and, of course, areas of ethics and confidentiality but just as much in motivation as understanding the addictions of self, where to send people, how to manage people in your systems, these core competencies really are inviting and assuring to the peer. They just love it. And the more they get it, that the more they

feel part of the overall initiative to address mental health and substance use.

Forty-two states now offer certification in becoming a peer, some-- in all 42 in mental health, some in-- a few in number 38 in just substance use peers with mental health. So it varies. You want to check your state to see if they have such programs. I know in the six states related to the Great Lakes ATTC, all do have peer certification programs, and that's how you begin the process of how do I become a peer.

Salaries. It's interesting. Salaries vary around the country, mostly where the location is and how rural or how hard it is to find peers. Generally, on an average, a peer is paid about $16 an hour or about $32,000 a year. Those states that have Medicaid reimbursement and have insurance reimbursement. Private insurance may pay higher. An agency maybe they bill higher.

However, Medicaid does pay for peers in those states in which there is a lot of certification existing, so it's something that you can certainly look at. It's not a matter of you can start with a grant, but once you get the grant, then you get certified you get into the process. There are ways to achieve reimbursement for your peers.

Practice guidelines and clinical supervision. There are guidelines for that and a little footnote for-- I'll show you in a minute-- where you can find those again. Some states have it, but mostly the international and national certification bodies are the ones coming out with these guidelines. And they really are helpful to peers.

Building career ladders. This is another key, key element. And I want to be able to-- don't just address a job for a person. Address the person coming into a job where they may also find a career. And in this case, I have two examples to share with you that you may want to check. One, again, is in Hancock County where the University of Findlay and the county joined to develop peers through a peer development program at the university.

And they now offer with the help professions that they do offer also a degree in getting certified as a peer. So a person can get a degree in nursing or social work and also have a peer certification. And if they decide to go one to a substance use master's degree or larger degree, they can do so. So they really have access to a career.

University of Rhode Island has that, and I was pleased to hear Dr. Chasek discussion of how Nebraska has a similar program. So this is the concept. Remember career ladders, not just

jobs, and you'll really be able to keep your careers.

Career satisfaction, talking to your peers as they are employed. Usually at midstream and earlier and feeling like they have a team and an involvement. Some agencies adult peer networks in their community, which again in some of the communities I've mentioned have support groups at the recovery centers where peers can gather and just talk about supporting one another, particularly when they aren't employed in agencies, and they are the 80% volunteer.

Inclusion and solution of leaderships in the community. As they say, nothing about me, without me and having peers involved in every decision is just the soundest way for you to ensure an adoption of activity within a community and having peers at all workforce levels. You want to have opportunities in the rural areas they found for spouses and family members so that peers are enhanced.

The idea that somebody can come to work at various times and perhaps a spouse or family member can come to with them and find other activities-- volunteer activities to do the agency. But creating a sense of belonging, of importance in the community and having something to give back, which is so critical for peers within the fellowship, that's their 12 step work. But it's just the message that peers want to do. They want to restore something to the community that they often feel that they had taken something from.

Create supportive work environment we've mentioned. Offering transportation to peers, again, that's a big dilemma. They come along, they meet a person who needs help, but they can't get them to the detox or the rehab. There's no transportation. They need resources or certainly helped to do that. And one concept I saw, which was interesting, was peers starting to their own Uber operations where they would take a person as becoming an Uber driver.

Activity support. Many peers will get active, but then they need business cards or posters or or little things to skirt for a booth at a festival. And really that's something where I think we can just put a little bit of money in and get a lot of reward. And they need stability and flexibility of schedule. Peers often have other jobs, so they need to be flexible. But you can certainly work with that flexibility and make yourself highly effective.

Some new players that have come along in the last two years-- as I mentioned there were many peers-- if you looked at William White's book began the 2009 reference, you'll find different kinds of societies of peers. But here I'm talking specifically about peer recovery

supports where a person is designed to work at any level of recovery. So these particular peers are making themself a little more distinct and working in agencies or working with individuals. First responders but their goal is to ensure people get into a basis of recovery and stay in recovery over a long term.

It's a chronic illness. We all know that the length of treatment cannot match the required years often needed to get to full recovery where a peer can do that. And these peer recovery supports can do that. A peer recovery coach is, again, a newer refinement. Many people use it as interchangeably with a peer recovery support. It is in some areas, but it is really evolving a little more now to become almost a coach for recovery and oftentimes even a private practitioner doing recovery coaching.

A family, peer support has become invaluable in the overdose problem we have currently in our country. And it's really just been the kind of needed service where people can help each other, both in preventing overdose like-- as an extension to Al-Anon but also as coming in and helping people deal with grief and loss. And there are so many of these wonderful programs. I think of Bridge to Hope in the Pittsburgh area where 400 or 500 parents who have experienced overdose will come together and just help each other through this tragic loss.

Are peers effective You bet. I said, yes, but that was mild. There have been recent studies in the past 10 years, and SAMHSA has a wonderful document, two pages of defining what a peer support is and what a peer recovery coach is. And then on the second page of this wonderful little document they highlight the studies-- numerous studies, actually 20 of them, that show that peers improve relationships within the provider organization, increased treatment retention, increased satisfaction with treatment, improve access to social supports in the community, particularly housing while reducing criminal justice involvement, decreasing in emergency room utilization, relapse rates, et cetera, et cetera. So the science is coming in very strong that peers are very effective, particularly when you consider the cost.

And hope. Most of all, what peers offer is hope. By sharing their experiences, peers bring people into recovery and families and promote a sense of belonging to individuals and self-empowerment to hope in the community. Resilience, they build resilience. They will build a prevention program as you strengthen them and make them into your future. I just can't say more than anything that they offer hope. They are the walking example of recovery.

Resources, I wanted to end on this particular slide because these are links to where you can

get key references with aids. People are saying, where can I get some of these materials. This is a link that you can just click on and find. I did mention the link to Ellyn Schmiesing and the Focus on Friends and one of the slides that will get you your peer guide.

Also some of the information a the University of Findlay. So you have that, or you can email me. And I'll be happy to provide any of these citations or references to you that I can give in copyrights. And that's really it. The last line as my references for today, but I'm hoping now we'll have some great dialogue on convention or conversation and turn it back to you, Michael.

MICHAEL HOAGIE: Maureen, you want to jump in here with some questions for our presenters?

MAUREEN FITZGERALD: Sure. Thanks very much, Dr. Flaherty and Dr. Chasek and Dr. Hoagie moderating our session. First question came in for Dr. Chasek. And that is have other states adapted your ambassador program?

CHRISTINE CHASEK: That's a really great question. I don't know if they have yet. However, a couple of states have contacted us to try to put something into place similar in their state. Illinois was one state that it contacted us. And I do think a lot of states are starting to through their Department of Education address behavioral health careers in their education program.

And so us coming alongside them and helping I think just expanded that an exploded that. And so I guess the answer to that question is I don't know if anybody has adopted it. They haven't let us know if they have.

MAUREEN FITZGERALD: Thank you. And it does sound like a great strategy. For Dr. Flaherty, are there any national standards for peer support staff? And could someone who is a peer specialist in one state give it similar job in another state without additional training?

MICHAEL FLAHERTY: That's a great question. There are national guidelines for peer support staff. And the ICNRC and NADAC both have them. And they are the major national credentialing bodies in the world of substance use at least. And then mental health and substance use, of course, SAMHSA, but those are guidelines. The-- they are not-- there is no per se national certification that would carry you and every state that I am aware of. However, each state, though, has guidelines, and they're pretty similar, mostly requiring about 40 hours of clinical training and 500 hours of volunteer time or some to get started, but each state has to be checked.

As far as the interstate acceptability of it, I don't think there are any one credential that would

allow you to go from state to state. But I do believe by getting the basic core training, which is similar in each, you probably wouldn't have very great in difficulty in getting certified in another state.

MAUREEN FITZGERALD: Thank you and another related question is, where can people find more information on the program at the University of Findlay?

MICHAEL FLAHERTY: Well, as I mentioned in the earlier slide, going back to the Focus on Friends program in Findlay or to just send me an email and I'll be happy to send you that information or connect you to Precia Stuby who's the director of Hancock County and who helped formulate that program with the University of Findlay.

MAUREEN FITZGERALD: That's great information. Let's see if we have any other questions that have come in. There we go. I'm starting in adolescent substance use and behavioral health disorder agency in Chicago, and I'm in need of a medical director. I'm aware of the ASAM website but cannot afford the fees. Any suggestions on recruiting a top level professional like this.

CHRISTINE CHASEK: This is Dr. Chasek, and I would just say it definitely sounds like a challenge for sure. And I would just go back to my point of connecting with those training-- those universities that train people that you need like that. So a medical director, maybe somebody, a med center that trains addiction psychiatric residents, babies. If you want to see a psychologist, maybe those that are in Monroe Meyer. We have Monroe Meyer Institute on our campus at the Med Center, and they train and place a lot of psychologists in that way so that might be an area where you can find those top level people that are just coming out or going into residencies and such connecting with them.

I did want to share, too, that we came full circle in terms of we started with in our program training psychiatric residents and getting them out into the rural areas. Now we've come full circle that we-- since we've included more professions-- we're starting an Addiction Psychiatry fellowship program, which has been an unexpected benefit for us in focusing on creating those partnerships. We now have a fellowship where they can focus on Addiction Psychiatry, which is much needed.

So that would be-- I guess that would be my suggestion. Those wouldn't-- you don't have any fees with that. Just find out who is the program chair director of the programs that would train the people that you want and put out an email or a call.

MAUREEN FITZGERALD: Thank you. Dr. Flaherty, do you want to add anything to that or Dr. Hoagie?

MICHAEL FLAHERTY: I think that that answer was great. You have to recall also that the American Psychiatric Association also certifies in addiction medical practitioners. But between ASAM and that-- and you can usually directly call doctors or who are ASAM certified and speak with them. They are very open to giving you names of doctors who may be able to help you recruit others that are in that-- some communities, particularly rural, are going at-- again, Findlay is a good example in Hancock County-- university-- where the brilliant nurse practitioners because there are a shortage of doctors in-- the medical doctors in the addictions and mental health, they're going after nurse practitioners who can also write prescriptions and treat behavioral disorders with proper training.

MAUREEN FITZGERALD: Thank you. Our next question is about logistics. Many agencies have restrictions against hiring people with criminal records, and yet many in recovery have had legal complications in the past. How are agencies working around this?

MICHAEL FLAHERTY: Well, I'll take it first if Dr. Chasek wants to go second. But that question has often been removed in a substance use arena unless you're working, of course, with children and there's a related event to children. But it has almost become a form of discrimination, so when you're asking the written question is one thing to ask it but verbally you can ask it, of course, with some care.

But you have to understand that, yes, indeed many of the people in the very population of peers have had that experience, and in some cases that may be their asset. But you have to go into the years of recovery and how strongly that recovery is. It's very hard for many to avoid criminal justice in this particular illness.

MAUREEN FITZGERALD: Thank you.

CHRISTINE CHASEK: Yeah, I would just add to that that that certainly is a challenge. And when I was hiring people in that situation, number one, we looked for them to have a license. And that was the first requirement. And in our state, we vet those people through the licensing process where they have-- their background has been checked. And if they have been able to be in a sustained recovery process where they then are free from legal issues, they're awarded a license.

And so that was one of our checkpoints. If they had a license, we knew that that process had been taken care of. It sounds like these are agency policies. One of our agency policy then was if you had-- if you were on the child abuse, neglect registry or maybe the vulnerable adults registry, we were not able to hire them.

But other things I think is what Dr. Flaherty just talked about, trying to be a little bit more understanding around that. And so it is hard when you have laws that go against what you're trying to do in the hiring process. That's just really unfortunate all the way around.

MAUREEN FITZGERALD: Thank you, Dr. Chasek. Our next question is what about career pathways for peer support? What work is happening to connect peer support specialists to other behavioral health professionals or other professions that assist communities in recovery as a whole from addiction-related issues?

MICHAEL FLAHERTY: Well, I mentioned quite a few things. You do not want to think of a peer just as a peer generally, especially if they're looking for careers. In many places where I work with the origination of peers, just having a meeting of people in recovery opens up from that group a number of people say I want to become a peer. And once they see the training and the opportunity to help others, that very value opens up to how do I become one.

And then from there, it opens up to where do I get formal training and what are the options for continuing as a peer volunteer or becoming employed? And then from there, it gets into if I get the academic training, why not just get a degree? So you're opening up by attaching your peer development to a university or community college.

And in the case of Findlay, they actually changed some requirements so that people could have access to a major university in their community-- or university Rhode Island. So they would enroll in a psychology or a social work or a nursing program but get a joint certification as a peer with an opportunity then to go two more years and get a degree as a social worker. And then from there, they were opened up to the same career path as you or I or many of the people in the audience.

In some communities, it is just so rural that the absence of medical practitioners I've seen, peers are becoming the safety net. They're becoming trained in operating safe needle exchanges or outreach to people with HIV. It's just such a critical service.

And then from there they become engaged with the health system and open up doors that

they might become further trained. The question of this from Nick is really-- or from the person who did ask it is really good. You do not want to think of a career, and it won't let you. Once you bring peers in, they'll-- they themselves will start asking you how do I get more? Where can I go? And it's great to get to a population that is currently very unemployed and make them an active worker in our field.

MICHAEL HOAGIE: This is Michael Hoagie. if I can jump in here for a moment. This is coming a little bit more from the mental health side but with respect to peer specialists. I have heard more and more about people being concerned about the career pathways issue because for peer specialists in a peer specialist role, there tend not to be multiple levels or many levels that affords career advancement in peer specialists capacities. And there are also individuals who are ambivalent about moving from a peer role into a professional role or confused about how to blend those if they were to pursue a professional degree after having been a peer specialist.

This is an issue that we face with the direct care workforce in general that individuals who have not had advanced training often find themselves without a lot of ready opportunities to advance up a pre-established career ladder. But I do really like Mike Flaherty's response though about there's a lot of energy that comes with peers. And I think our field is in a point now where we're just beginning to further explore that whole notion of career advancement. There's been such a rapid explosion of peer in peer specialists in the nation, and so these questions about where to from these roles are really an area of focus at this point in time.

MICHAEL FLAHERTY: Yeah. If I could add one point to Michael, the opposite is also evident in my work with peers around the country where many times peers will begin the process, get the education and then will realize as a volunteer peer mostly that they want to continue being such but not necessarily certified, which is sounding odd. But they feel that sometimes the formalization of the process itself, they lose something of what they really want to be in being a peer in their community.

So it's a two-way street is what I'm trying-- you have to be open to that with your peers and those that say, no, I do not want to go on. I want to stay right here and be this almost 12-step worker in my community. But this added training, I certainly respect that, too.

MAUREEN FITZGERALD: Thanks, Mike. Dr. Michael Flaherty and Dr. Michael Hoagie, thanks to both of you. We're at the top of the hour now, and we can see if a couple of more questions come in. We were scheduled to meet just until noon today or 'til that central time, depending on your time zone.

MICHAEL HOAGIE: If there are no questions-- this is Michael Hoagie-- I just wanted to comment just in listening to these two presentations. Part of what-- if you listen to some of the other series sessions, number one and two in this series, there's some themes that are recurrent. We've heard across each session some information about states who have put some money on the table through initiatives such as BEACON the Dr. Chasek was talking about or in the Department of Public Health in Massachusetts, which has a workforce coordinator. And I think it's clear that those efforts, they attract to them other resources. So it's just-- these are examples at the broadest scale of the benefits of states focusing and creating some sort of workforce infrastructure.

We've heard other themes. Dr. Chasek talked about the importance of starting early. We know that's true about recruiting individuals into any kind of field, so this reaching out into high schools as a perfect example. Making connections with academic centers or training institutions as a way to grow your workforce in part by offering internships to students is a theme that has recurred across each of our presentations. We heard it as a general strategy. We heard it as a strategy for recruiting persons of color. We're hearing it today again about a strategy for recruiting people into rural positions.

Cobbling resources together is something that we've heard about, the need to be creative and pull different pieces and people together. And then I think Michael has given us the sort of real powerful sense of the interpersonal and attitudinal issues that underlie all of this and are so fundamental when we think about engaging peers and making our organizations hospitable to peers playing a major role in them as well as on thinking about professional recruitment as well. So these are some of the themes that have been echoed throughout, and I hope that you will think about as you think about your own efforts at recruitment and retention in your organizations.

I don't see any additional questions, so I suggest we call it a day and thank-- I want to thank Dr. Chasek and Dr. Flaherty for bringing all of their knowledge and talents to this webinar and to the Great Lakes ATTC for their enormous help in hosting and producing this series. So thank you all.

MAUREEN FITZGERALD: Thank you. Just want to remind everyone that the webinar has been recorded and will be posted on the Great Lakes website within two weeks. And you'll also be getting instructions on how you can earn your CE for this webinar. Thank you everyone for joining us today.