health share
Health Share of Oregon

2016 MetroPlus Substance Use Disorder Peer Delivered Services Survey

Survey of Substance Use Disorder & Co-occurring Peer Delivered Services in the Portland Tri-county Metro Area

Survey of 34 Peer Programs & 124 Peer Delivered Service Supervisors and Peers

Eric Martin, MAC, CADC III, PRC, CPS
Michael Razavi, MPH, PRC, CADC I, CPS
Johnnie Gage, M.S., CRM
Jeff Marotta, Ph.D., NCGC-II

May 2016

2016 MetroPlus+ SUD-PDS Survey

Survey of 34 Tri-county SUD/Co-occurring PDS Programs
Survey of 124 PDS Supervisors and Peers

Eric Martin, MAC, CADC III, PRC, CPS
Michael Razavi, M.P.H., CADC I, PRC, CPS
Johnnie Gage, M.S., CRM
Jeff Marotta, Ph.D., NCGC-II, CADC III

Data Collection and Estimates

An informal survey of 37 MetroPlus peer programs serving (SUD) Substance Use Disorder clients in Clackamas, Multnomah and Washington counties was completed in April 2016. This Administrative Survey includes data collected from agency websites, completion of a survey form regarding staff and clients served, and outcome data. Surveys were conducted through email forms, and phone interviews. 84% of the 37 programs were able to respond to the survey and submit program estimates. Program administrators made estimates regarding clients served, percentages receiving SUD peer services, funding estimates, and accounting of staff and FTE's. From those figures, data approximations regarding all tri-county SUD PDS clients and staff were projected.

Clients served monthly	3,619
Tri-county Estimate	*(X*.84 = 3,619), x= 4308.333333*
Volunteer Peers	18.3
Tri-county Estimate	*(X*.84 = 18.3), x= 21.785714*
Employed SUD/Co-occurring Peers	*236.7*
Tri-county Estimate	*(X*.84 = 236.7), x= 281.785714*
Total FTE's	*201.6*
Tri-county Estimate	*(X*.84 = 201.6), x= 240*

Surveys were emailed to 338 individuals in the tri-county area involved in the supervision and delivery of SUD peer services. Over 300 of those individuals were certified CRM's/PSS's. Survey questions were designed from interviews, stakeholder discussions and a review of the literature (BRSS-TACS/White).[1] 124 individuals responded to the survey, with a response rate of 36.6%.

Survey Results

There are an estimated 4,308 addiction/co-occurring peer clients that receive Substance Use Disorder (SUD) specific peer services in Multnomah, Washington and Clackamas counties, served by 304 peers.

There are few, if any, addiction or mental health counselors, (college practicum students notwithstanding) who volunteer with any regularity within the professional behavioral healthcare system. Our survey reveals that nearly 8% of tri-county peers are volunteers (*fig.1*). Numerous State and federal documents have underscored the importance of volunteers in the peer workforce.

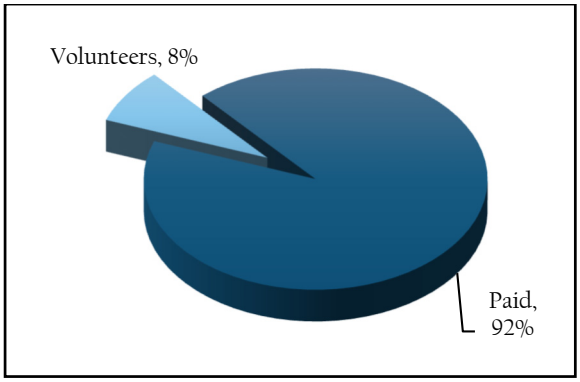


Figure 1 Percentage of volunteers in PDS programs (n=34 Administrators)

Uncompensated SUD/Co-occurring Volunteer Peers	**22**
Employed SUD/Co-occurring Peers	**282**
Total SUD/Co-occurring Peer FTE's	**240**

In the 1970's and 1980's, many addiction treatment programs utilized a volunteer workforce. Volunteer programs in addiction treatment, relying primarily on volunteers in personal/family recovery have been evaluated positively. Volunteer programs declined in popularity in the addiction field throughout the late 1980s and 1990s but are now increasing in tandem with renewed calls for peer-based recovery support services.[2]

SAMHSA has highlighted the importance of volunteer peer services and has raised the question of examining the efficacy and outcomes of volunteer peer services vs. paid peer services.

Research questions raised by SAMHSA[3]:

- Are volunteer peers effective?
- Are volunteer peers more or less effective compared to their paid counterparts?
- Could they be more effective because volunteers are more passionate, are "mission driven" and have a "calling"?
- Are they receiving an adequate amount of training, ongoing training and supervision compared to their paid counterparts?

In a 2011 Oregon Health Authority survey of 562 non-traditional health workers, OHA quantified the amount of volunteer hours performed by Oregon peer mentors.[4] While no actual percentage of volunteer effort was calculated in their analysis, these surveys and reports highlight the importance of retaining volunteer peers in the PDS field. According to our work groups, peers are most often initially recruited for paid work through their original volunteer efforts. Currently, the only threat to the volunteer peer movement appears to be exclusionary credentialing requirements. The Obama White House has recently released a report suggesting that America has become "over-licensed," further suggesting that over-regulation reduces available volunteers. Their report, Occupational Licensing: A Framework for Policymakers, July 2015, indicates that, on average, the immediate impact of licensing reduces available services on average 16%, disproportionately excluding minorities, and licensing reduces volunteerism. Additionally, research shows licensing has little impact on improving health and safety when analyzing

health and safety violations before licensing and after licensing. This report suggests, maintaining the lowest possible entrance requirements for voluntary certification with a focus on "health and safety" (vs. aspirational competencies), will promote inclusivity vs. exclusivity and will preserve volunteerism.[5] The report highlights that the two most significant threats to inclusivity are:

- excessive entry level educational requirements, including exclusive educational requirements
- and, criminal history background checks.

SAMHSA, the International Certification & Reciprocity Consortium, the International Association of Peer Supporters (iNAPS), BRSS-TACS, and the collective works of William White, have all made inclusive references in their literature with accompanying guidance regarding the importance and value of volunteer peer mentors. Many of these organizations discuss the importance of additional supervision with volunteer peers and mechanism for honoring their volunteerism.

Volunteerism is the current "vetting system" for entry into the addiction peer field. The current paths into the addiction peer field appear to be largely; 1) through an individual's volunteerism and participation in the recovery community (12-step volunteerism, etc.), or 2) an individual's volunteer efforts with peer delivered services programs.

With less restrictive requirements, peer delivered services are a more "volunteer-friendly" system compared to the larger behavioral healthcare system.

65% of tri-county peer programs offer services in multiple counties. Nearly all receive funding from multiple sources. (*fig.2*)

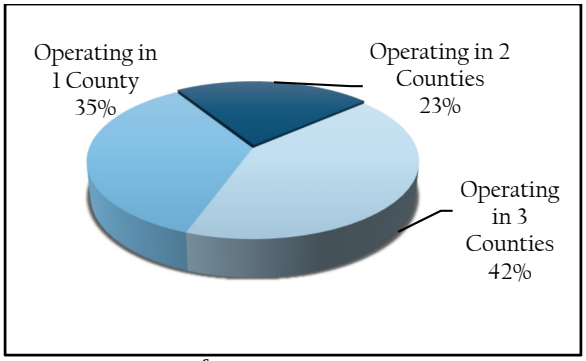


Figure 2 Percentage of programs operating in 1-3 counties (n=34 Administrators)

PDS programs have multiple reporting requirements for different counties, tracking different outcomes, and reporting data in different systems. Additionally, there are different reporting requirements for funding sources (e.g.; Counties, Child Welfare, ATR, OWITS, Corrections, and Drug Court) (fig.3). The Multnomah County Peer Delivered Services Community Input Meeting, November 18, 2015 echoed "Data/Evaluation" as a challenge for most PDS providers.

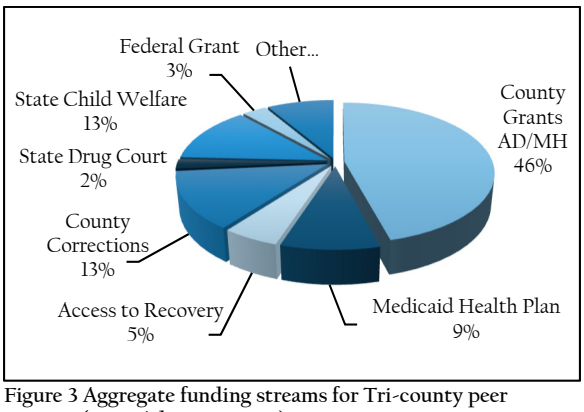


Figure 3 Aggregate funding streams for Tri-county peer services (n=34 Administrators)

Some key informants have recommended unifying data collection, data metrics, and collection systems to alleviate the burden of varied reporting requirements of different

counties and funding sources. Work groups also report that a significant amount of administrative and staff time is dedicated to training on multiple reporting systems and requirements.

Peers and supervisors were asked to rate their perceptions regarding the most important outcomes to monitor.

Surprisingly, peers and supervisors presented identical relative rankings and responses (*fig.4*, *fig.5*). Most outcome analyses focus on "cost savings" related to criminal justice expenses (police, courts, incarceration, supervision, etc.) and healthcare costs (hospitalization, E.D. usage, and healthcare utilization). Monitoring specific data related to cost savings, in order to secure ongoing funding for peer delivered services is pragmatic.

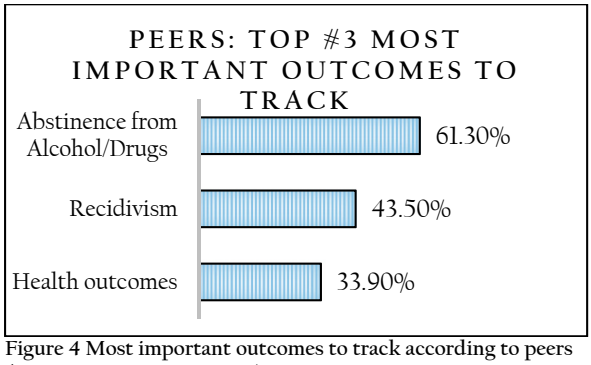


Figure 4 Most important outcomes to track according to peers (n=124 Supervisors & Peers)

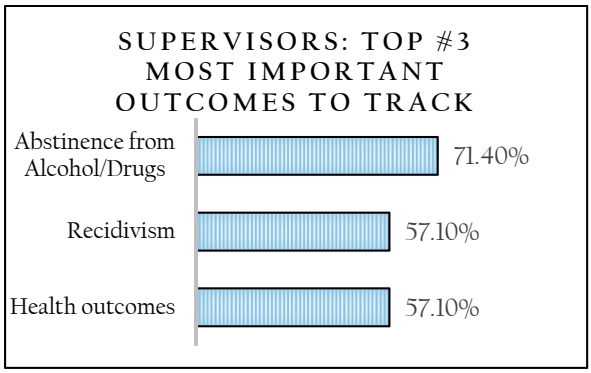


Figure 5 Most important outcomes to track according to peer supervisors (n=124 Supervisors & Peers)

Both peers and supervisors selected the same top three outcomes, with near identical rankings of importance: Abstinence, Recidivism & Health Outcomes. In our work groups, some administrators voiced concerns regarding peers and peer supervisors being too abstinence focused and concerns regarding their work with those participating in Medication Assisted Treatment and primary care clients with low levels of substance abuse where the goal may be reduced use vs. abstinence.

Highlights in Tri-county PDS Outcomes

In our surveys of programs, we elicited outcomes from Clackamas, Multnomah and Washington counties. Multnomah county submitted aggregate data from a variety of contracted programs, Washington county submitted data from their largest contracted provider Bridges to Change, and Clackamas county submitted aggregate cost-benefit calculations based on outcomes from several of their contracted providers.

Washington County: IRISS Men's Peer Support Program

Oregon Department of Corrections data reveals that 79.4% of prison inmates have substance use disorders, and nearly 60% have a history of addiction/dependence. The IRISS program provides peer support and sober housing for Washington County referred offenders. Sixty-seven percent of the participants completed the program. Many non-completers appeared to benefit from services despite their non-completion status (*fig.6*). Caucasians had the highest rate of recidivism. Hispanic clients had the lowest rate of recidivism. Their program completion rate is higher than the national average for outpatient substance abuse treatment services (67% vs. 42%). While most participants are simultaneously enrolled in Substance Abuse Treatment services. It appears that IRISS significantly augments completion

rates for offenders enrolled in outpatient substance abuse treatment services. A 2015 analysis by the Oregon Department of Corrections reveals that 53% of parolees are arrested for a new crime within three years of release, and 46% of felony probationers are arrested for a new crime within three years. IRISS Peer Recovery Services appear to dramatically reduce recidivism. While IRISS serves "high risk" offenders, three-year post sentencing and/or incarceration data is not yet available.[6-7]

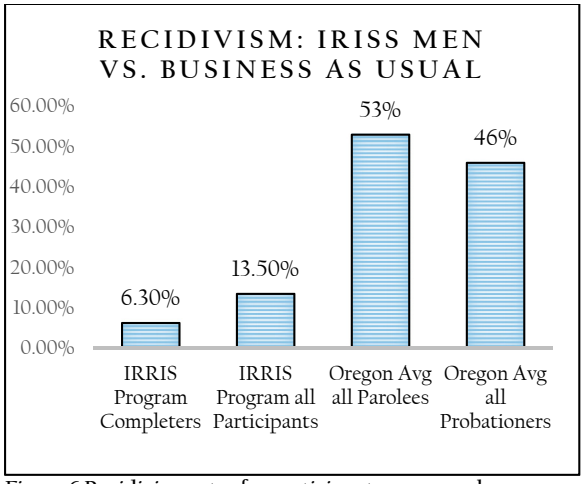


Figure 6 Recidivism rates for participants vs. general recidivism rates

Multnomah County: Aggregate Outcomes

As part of supporting a recovery-oriented system of care, Multnomah County funds recovery support services at 14 outpatient agencies—housing support, childcare, peer mentoring, telephonic/Internet-based recovery support, and skills training and development groups. They also directly fund three recovery support agencies—one providing peer mentoring to youth and young adults in recovery; one offering a variety of recovery support services, including peer mentoring, to clients before, during, and after treatment; and one African-American culturally-specific agency offering recovery mentors and housing assistance. 587 clients in County-contracted treatment facilities received a total of 2,526 hours of peer mentoring services from March 2014 through January 2016. They are excited to have obtained access to a number of new datasets that will allow them to begin examining a holistic range of outcomes for our clients, such as housing, employment, education, healthcare utilization, substance use reduction, and more; laying the groundwork for these new analyses is still in process at this time (*fig.7*).

95% of participants reported being able to connect with individuals in recovery (building a sober social support network).

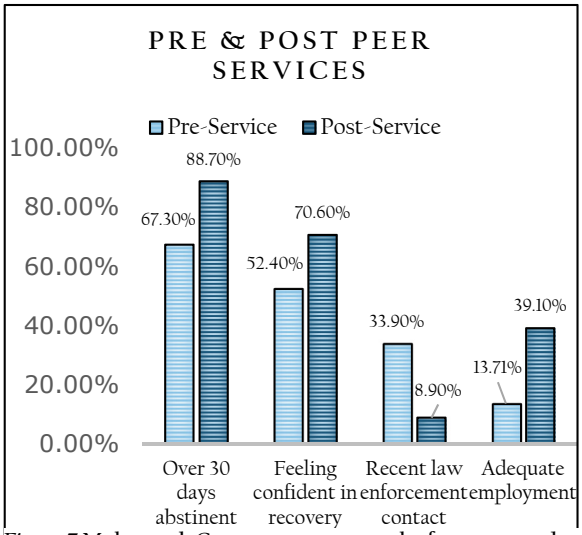


Figure 7 Multnomah County aggregate results for contracted peer programs

Clackamas County: Cost-Benefits

Clackamas County has a variety of subcontracted peer providers, including: Mental Health American of Oregon, Stay Clean, Cascadia Peer Wellness Specialists, Folk Time, Youth M.O.V.E. Oregon, The Living Room Drop-in, Oregon Family Support Network, NAMI, and the David Romprey Warmline. While much of their data is focused on mental health outcomes, nearly all of the subcontracted providers provide some level of SUD peer services to co-occurring disorder clients.

Clackamas Fiscal Year 2013-2014

1:1 Peer services: 1,687

Drop-ins served: 1,431

Total served: 3,118

Clackamas Fiscal Year 2013-2014: Estimated Cost Saving of 3 of 12 peer programs

Estimated cost savings to Jail: $1,288,710

Estimated cost savings to child welfare: $720,400

Estimated cost savings to system based on Warmline calls: $283,003

60% of tri-county peer programs are free-standing programs. Additionally, some licensed agencies subcontract services from smaller freestanding programs (*fig.8*).

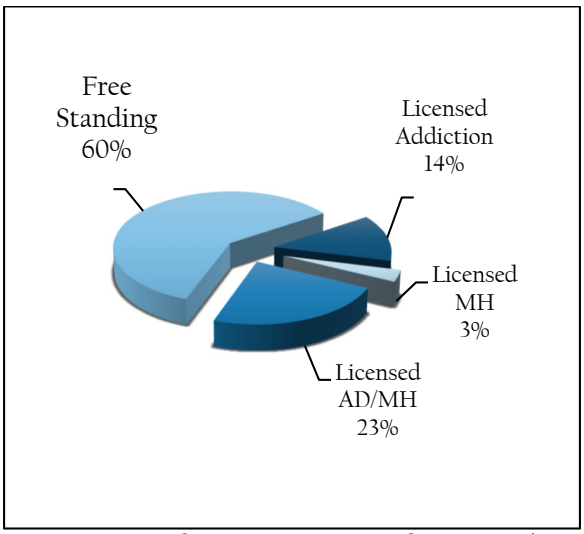


Figure 8 Freestanding vs. State Approved Programs (n=34 Administrators)

Freestanding organizations are not currently constrained by excessive administrative rules, auditing and credentialing, compared to State Approved addiction and mental health agencies. However, some freestanding programs need support with non-profit board, business/financial practices, and grant writing. Over-regulation of services may lead to over-professionalization of services. William White states, "Peer-based models of care can have a transforming effect on larger systems of care and on our society by enhancing long-term addiction recovery outcomes and elevating public and professional perceptions of hope for recovery. However, peer models of recovery support can also be corrupted and devoured by larger systems of care. As peer-based services are integrated into the existing treatment system or offered by free-standing independent organizations, there will be pressure to emulate the ethos of the existing treatment system, including the professional roles of counselors and others."[8]

Moreover, the White House Report on Occupational Licensing: A Framework for Policymakers, July 2015, reports that licensing reduces the availability of services. Research reveals that there is typically, on average, a 16% contraction in service providers when licensing ensues.[9]

In our survey of Peer Supervisors, 50% "Disagreed & Strongly Disagreed" with the proposition of licensing freestanding peer programs, 50% "Agreed & Strongly Agreed" with the proposition of licensing freestanding peer programs.

61% of 4,308 clients are receiving SUD primary peer services, while 39% are receiving Co-occurring Disorder peer services.

According to the SAMHSA National Survey on Drug Use and Health (NSDUH), 38% of those with a (SUD) "substance use disorder" present (AMI) "any mental illness" in the past year. 62% of U.S. residents with a SUD present no mental illness in the past year (see SAMHSA infographic next page).[10]

This data, collected in 2013 and reported in 2014, is consistent with prior annual surveys, and the 2013 NSDUH collected in 2012, reporting 37% of those with a (SUD) substance use disorder present (AMI) "any mental illness" in the past year. 63% of U.S. residents with a SUD present no mental illness in the past year.[11]
In our survey of program administrators, the division of "substance abuse primary" clients and "co-occurring" clients, appears to be nearly identical to the SAMHSA NSDUH national survey (*fig.9*).

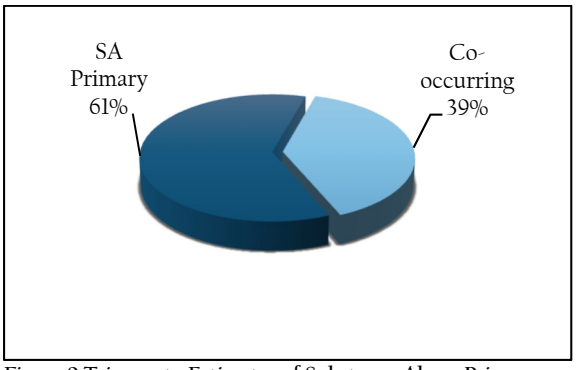
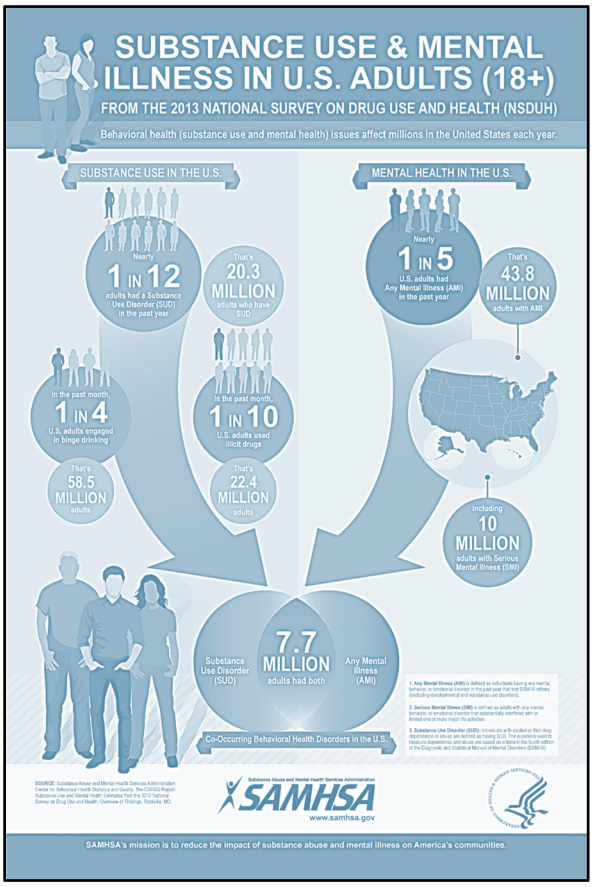


Figure 9 Tri-county Estimates of Substance Abuse Primary Peer Clients and Co-occurring Disorder Peer Clients (n=34 Administrators)

The prevalence of co-occurring disorders is heavily debated. The NSDUH survey is the largest annual epidemiological study in the United States. These data reflect rates of co-occurring disorders among substance abusers in the general population, vs. correctional populations, child welfare parents, individuals in residential treatment or co-occurring disorder treatment.

In our survey of Peers and Peer Supervisors, 86.7% of supervisors and 93.2% of peers reported that there is a need for more co-occurring disorder peer programs, and even more specifically SMI Co-occurring Peer Programs. Numerous individuals surveyed reported a severe service gap for those who are homeless with severe mental illness (SMI).



(NSDUH, n=72,000)

According to the National Survey on Drug Use and Health, among Oregon residents age 12 and older, 1 out of 11 present past year substance abuse or dependence (DSM IV criteria), slightly higher than the national average of 1 in 12 U.S. residents. There are 4,308 individuals receiving SUD peer services in the tri-counties, while there are approximately 1,386,000 individuals 12 and older residing in the tri-counties.

Our survey of peer programs in the tri-county reveals (*fig.10*):[12-13]

- 1 in 11 Oregon residents, 12 and older, would benefit from SUD treatment and/or recovery services.
- Approximately, 1 in 322 individuals, 12 and older, are receiving SUD peer services in the tri-counties.
- Approximately, 1 in 152 individuals, 12 and older, are receiving addiction treatment services.

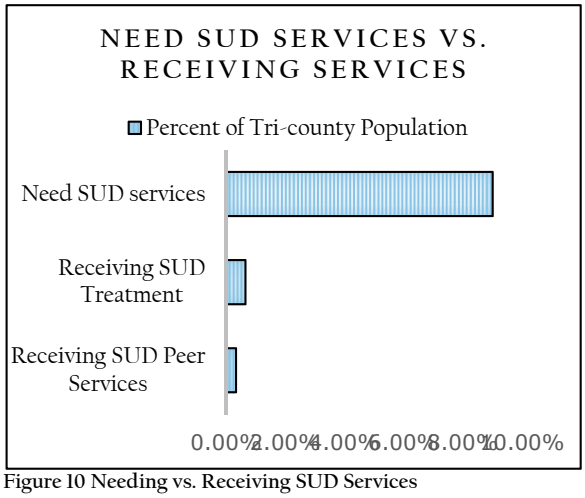


Figure 10 Needing vs. Receiving SUD Services

Moreover, Betty Tai and Nora Volkow, National Institute on Drug Abuse, National Institutes of Health recently published a journal article, Treatment for Substance Use Disorder: Opportunities and Challenges under the Affordable Care Act, wherein they postulate a system design that includes intervention into mild, moderate and severe substance use disorders. This is a larger population yet, over simply the historical epidemiological moniker of "abuse and dependence" (DSM IV). Dr.'s Tai and Volkow state, "The treatment of SUD must adapt to a chronic care model offered in an integrated care system that screens for at-risk patients and includes services needed to prevent relapses. Carving out the delivery and financing of behavioral managed care may have helped contain costs and improve the care for the more serious cases of abuse and addiction, but the disadvantage is that the majority of individuals

with mild and moderate substance use problems have missed the opportunity for early detection, timely intervention, and referral at an early stage of substance abuse."[14]

There are 22 volunteer SUD peers, 282 employed SUD peers, delivering 240 FTE's of SUD peer services. On average peers maintain a caseload of about 17.5 clients, with a median of 16.6 clients per FTE (*fig.11*).

Peers working inside of Community Recovery Centers, jails, treatment centers and recovery housing tend to have higher caseloads, while peers who work primarily "in the field" tend to have lower caseloads. Volunteers see fewer clients compared to employed peer mentors.

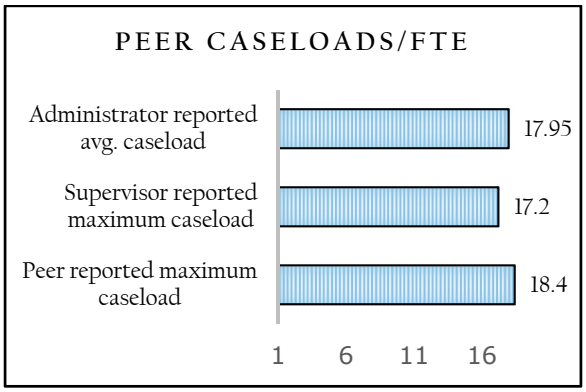


Figure 11 Caseloads reported by Administrators, Supervisors and Peers (n=124 Peers & Supervisors, n=34 Program Administrators)

Our survey of programs reports:

- According to administrators, the average client caseload is 17.95 clients per FTE, with a median of 16.6 clients per FTE.
- Our survey of Peer Supervisors reports, on average, the maximum case load should be 17.2 clients per FTE.
- Our survey of peers reports the maximum case load, on average, should be 18.4 per FTE.
- The average of all data points is 17.5/FTE.

Peer wages average $14.68/hour, and supervisors earn on average $20.87/hour.

Supervisor Wages: average wages for supervisors are $20.87/hour, the median wage is $20.50/hour. 85.7% reported that they "agree or strongly agree" that their wages are fair. 14.3% reported that they "disagree or strongly disagree" that their wages are fair (*fig.12*).

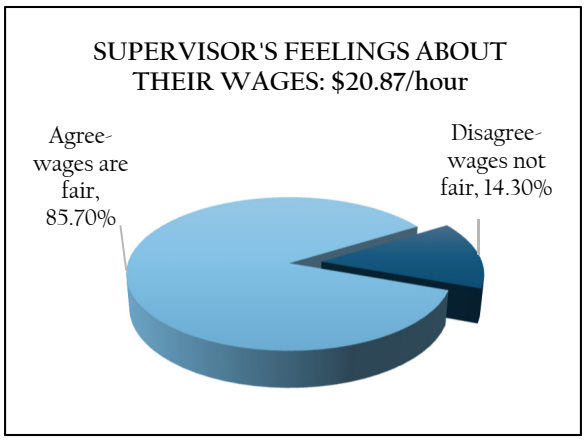


Figure 12 Supervisor's thoughts about their wages (n=124)

Peer Wages: average wages are $14.68/hour, the median wage is $14.50/hour. In 2013, ACCBO completed a salary survey that included CRM peers, at that time average wages were $13.66/hour. It appears that peers have experienced an average increase of $1.02/hour over the past three years, approximately a 2.3% annual increase in wages. Less than half of peers, 40.4% reported that they "agree or strongly agree" that their wages are fair. 59.6% reported that they "disagree or strongly disagree" that their wages are fair (*fig.13*).

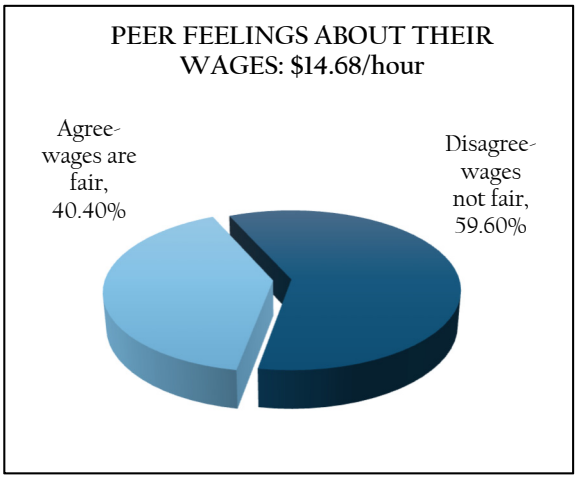


Figure 13 Peer's thoughts about their wages (n=124)

Historically, surveys of addiction treatment program administrators report no perceived differences in the effectiveness of recovering counselors vs. non-recovering counselors, but they pay recovering counselors less for comparable work. Olmstead and coworkers, analyzed salary data from the 2002-2003 National Treatment Center Study and found, after controlling for education, years of experience, and certification/licensure, etc. recovering counselors receive $1,000-$2,580 per year lower salary compensation. The researchers theorized that this was due to fewer job alternatives (criminal history) and the passion that recovering counselors have for their work.[15] People in recovery from addiction are more likely to have a criminal history as a legacy of the war on drugs. ACCBO's 2013 Survey of Peers & CADC's (*n=501*) revealed that 100% of SUD peers surveyed reported a history of arrests and/or convictions. Job mobility is of great concern to these individuals due to the possibility of rejection due to criminal history. With tri-county minimum wages heading toward $14.75 over the next five years, peer programs will need to keep pace, simultaneously, key informants have expressed their concerns regarding skyrocketing commercial rents and expenses, and their capacity to raise wages.

Our survey reveals that both supervisors and peers are concerned about future criminal history prohibitions that may be put in place effecting peers and addiction treatment staff (*fig.14*).

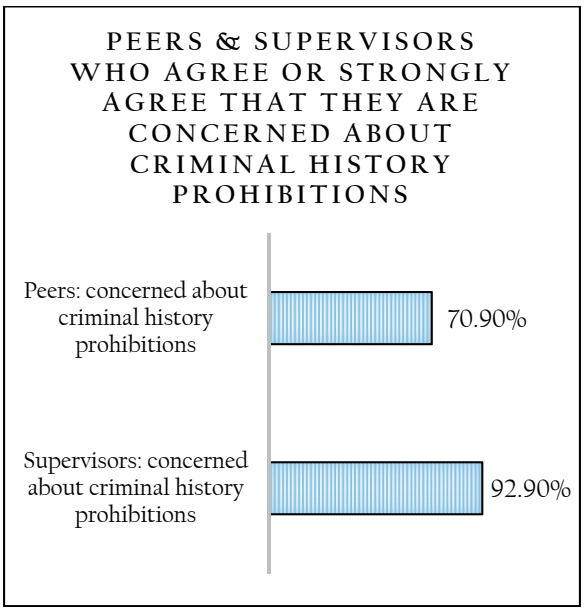


Figure 14 Supervisors and Peers concerns regarding criminal history prohibitions (n=124)

52.5% of peers want to leave their current peer position. Many are seeking to advance to CADC certification.

Supervisors report an average annual turnover rate of 19.5%, similarly 18.0% of peers report a current desire to leave their peer agency to seek employment at a different peer agency, or leave the field entirely. 34.5% want to advance, primarily to CADC I certification (*fig.15*).

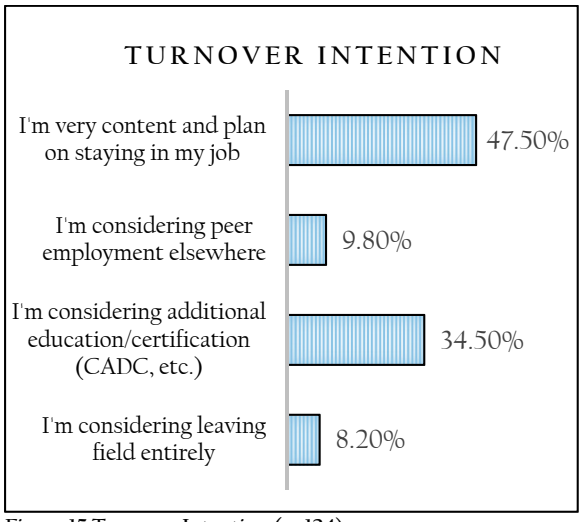


Figure 15 Turnover Intention (n=124)

52.5% of peers report a desire to move out of their current job; either to advance, move to another agency, or leave the field entirely (*fig.16*). Supervisors report an average past-year turnover rate of 19.5%.

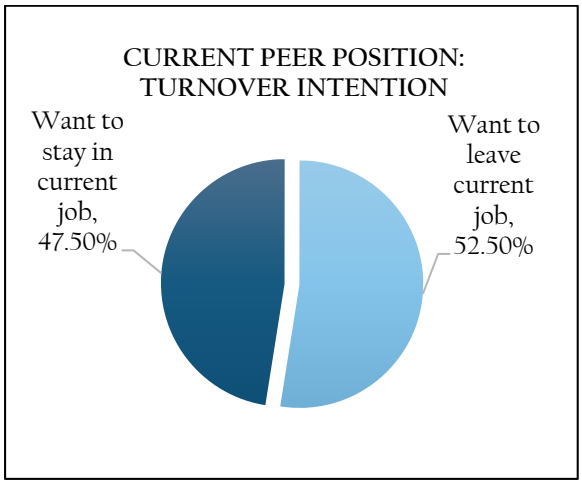


Figure 16 Aggregate turnover intention for current peer position (n=124)

Multiple Credentials: What credentials do tri-county SUD/Co-occurring peers possess?

Based on our survey of programs, it's estimated that of 304 tri-county SUD/Co-occurring peers, 73% are ACCBO CRM(PSS registered), 19% are OEI-only PSS(and/or PWS), and 8% have training but no certification yet (*fig.17*).

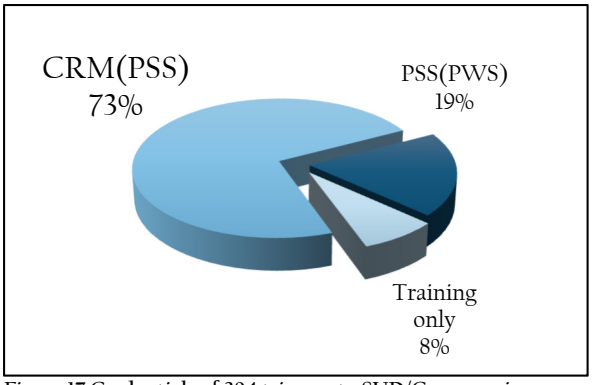


Figure 17 Credentials of 304 tri-county SUD/Co-occurring peer mentors (n=34 Administrators)

- 22% of CRM's are also CADC's,
- and 7% of both CRM(PSS) and PSS(PWS) are also QMHA/P.
- An additional 34.5% are pursuing advanced education and credentials.

Over half of peers believe an experienced peer should be the minimum qualification for SUD peer supervisors. Over half of supervisors believe a CADC should be the minimum qualification for SUD peer supervisors.

Over 1 out of 5 CRM's are dual certified as CADC's. 57.1% of SUD peer Supervisors believe the minimum qualification for an SUD peer supervisor should be CADC certification, compared to 50.8% of peers believing an experienced CRM/PSS should be the minimum qualification for an SUD peer supervisor (*fig.18*).

Only 5.1% of all those surveyed believe a graduate level CADC III should be a supervisor. No one, 0%, of all those surveyed, thought that a QMHP or licensed mental health professional (LPC, LCSW, etc.) should be minimum qualification for an SUD Peer Supervisor.

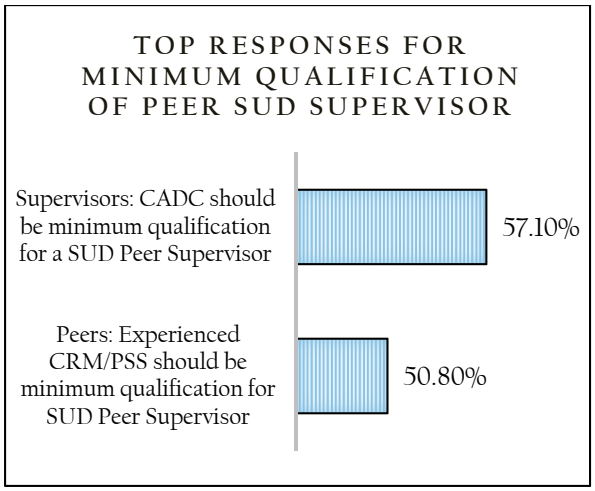


Figure 18 Opinions of supervisors and peers regarding the minimum qualifications of a "Peer Supervisor" (n=124)

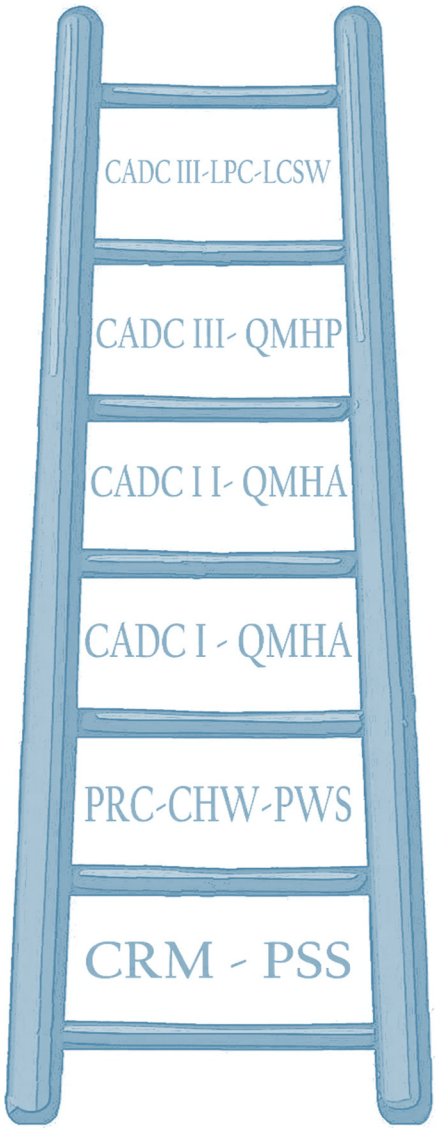
Our workgroups recommended that if a licensed mental health professional was required to be a part of supervision for reimbursement purposes, that supervision should be co-led by the graduate level professional and an experienced peer.

Career Ladder: Over 1/3rd of peers are seeking advanced credentials. Many peers seek the assistance of their supervisors to advance in education and credentialing.

As previously reported, 34.5% of peers report they are pursuing advanced credentials (PRC, CADC, etc.). This is an important finding in this survey. With over 1/3rd of peers seeking advanced credentials and income it is important to understand the "career ladder" for peers. Most SUD/Co-occurring peers seeking advanced credentials are pursuing CADC I certification.

- 93.3% of supervisors report that they are assisting peers in advancing their credentials.

Maintaining a career ladder may help retain SUD/Co-occurring peers in the SUD recovery field, who might otherwise abandon the field for other more lucrative occupations where advancement is more feasible.



72.5% of peers report that supervision meets their needs.

Current supervisors in tri-county PDS, are a mix of CADC's, mental health professionals, and experienced peers. Most are in recovery themselves, but not all have prior occupational experience as peer mentors.

- 100% of supervisors report that they "agree or strongly agree" that their supervision meets the needs of the peers that they supervise,
- while 72.5% of peers "agree or strongly agree" that the current supervision meets their needs, and 27.5% disagree (*fig.19*)

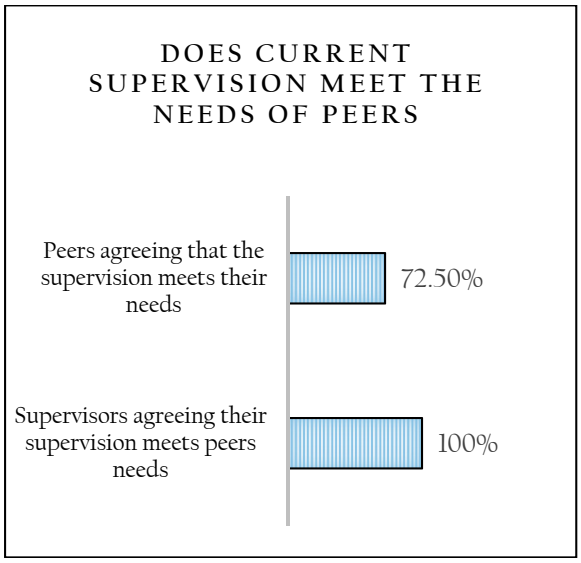


Figure 19 Supervisor and peer opinions regarding efficacy of supervision (n=124)

These results are similar to a study of Peer Support Supervision through the Veterans' Administration in 2010. In that study, 77.3% of peers agreed that their supervisor did a good job, compared to 97.0% of supervisors who agreed that they did a good job as supervisors.[16]

In the tri-counties, there are at least seven SUD "Community Recovery Centers" where individuals "drop-in" for a variety of support groups and meetings. Additionally, many programs have "Outreach Workers" who see many undocumented people, of which a smaller number will convert to "enrolled" status. There are also numerous mental health drop-in centers that also provide some level of SUD peer support.

Community Recovery Centers serve more individuals that simply "enrolled clients." Many individuals who "drop-in" to Community Recovery Centers are not enrolled clients. Many of these individuals seek low levels of support (locating resources, etc.), but are not seeking peer services, or are considering peer services and are undecided. Moreover, many terminated clients who have graduated from services, return to Community Recovery Centers periodically for occasional support or assistance. Due to the informal nature of peer support, many former clients return, without appointments or re-enrollment for ongoing assistance. These SUD Community Recovery Centers, include: 4th Dimension Recovery Center, Family Recovery Support – VOA, CEP – CCC, the Miracles Club, Youth Move, Washington County NAMI, and NARA. Our survey of peers and programs report that over half see undocumented clients on a weekly basis, and many of these clients are seen in "drop-in centers." Additionally, outreach workers serve primarily undocumented clients. One key informant states, "when we're pulling people out from under bridges, these folks are not enrolled. An outreach worker may be seeing eight people, and one will convert to an enrolled client."

- *55.7% of peers report un-enrolled contacts occur weekly to daily (fig.20).*

- *We are sorely lacking solid data on "SUD drop-ins" or "outreach contacts."*
- *Ally Linfoot from Clackamas County reports, in FY 2013-2014; mental health/co-occurring providers performed 1:1 peer services for 1687 clients, and provided services to 1,431 "drop-ins."*

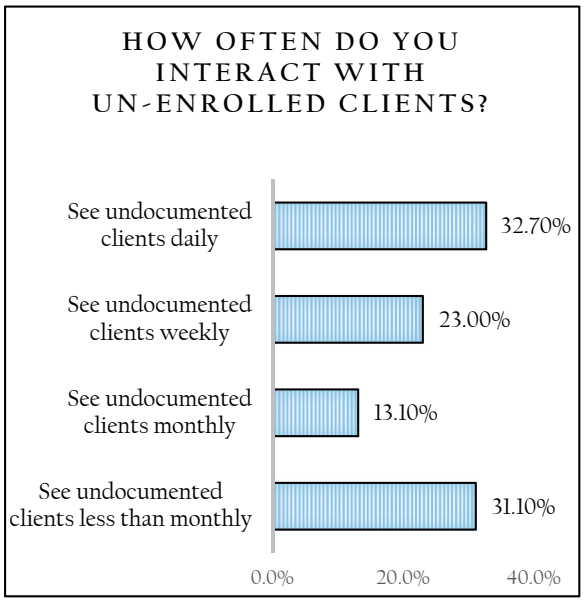


Figure 20 Frequency of contacts with un-enrolled clients (n=124)

In their journal article, Treatment for Substance Use Disorder: Opportunities and Challenges under the Affordable Care Act, Betty Tai and Nora Volkow, state, "These changes of proactively seeking and screening patients with a SUD (who are often reluctant to seek help) and their long-term engagement in treatment will be able to substantially increase the number of effectively treated SUD patients. These proposed changes fit well within the Affordable Care Act (ACA) of 2010 and the Parity Act of 2008 because this legislation requires that the SUD treatment coverage is 'no more restrictive' than all other medical and surgical procedures." They also propose, "changing from an episodic acute model into a chronic care model (CCM) attuned to the chronic and relapsing characteristics of SUD".

In a climate, moving away from mandatory criminal justice based services, towards voluntary services offered through client-finding, these thought leaders propose "proactively seeking" clients and responding to clients in a long term (CCM) chronic care model, yet there is little funding for outreach and no funding for post-termination follow-up.

Unreimbursed services for un-enrolled clients and "drop-ins" may be unsustainable in the future, depending on payment mechanisms. This is most especially true for Community Recovery Centers and programs with Outreach workers.

32% of tri-county PDS programs offer culturally specific services (*fig.21*)

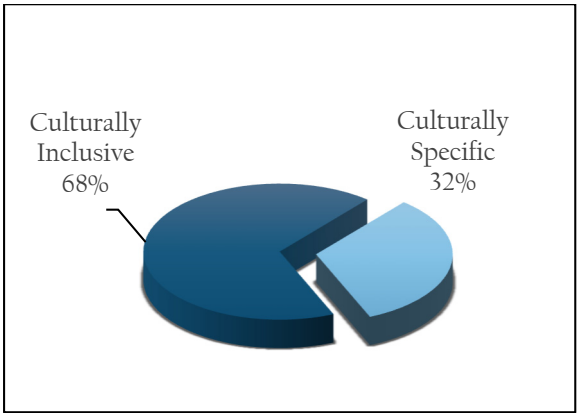


Figure 21 Percentage of tri-county SUD/Co-occurring PDS programs offering culturally specific services

Hispanic/Latino clients may be the most underserved population in the tri-counties. Data from Treatment Episode Data Sets, 2013, reveals that nearly 10% of all Oregon Addiction Treatment Admissions are Hispanic/Latino, while 5.4% of peer programs offer SUD Hispanic/Latino services, and only 5.2% of Oregon CADC's and Peers are Hispanic/Latino (*fig.22*). In our survey, 1/3rd of peers and their supervisors ranked cultural competency as an important training need for peers in the tri-counties.

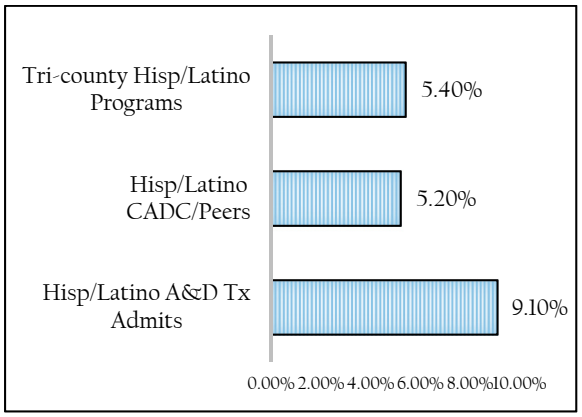


Figure 22 Percentage Hispanic/Latino clients enrolled in addiction treatment services compared to the percentage of Hispanic/Latino programs and the percentage of Hispanic/Latino SUD staff.

Peers and Supervisors report co-occurring homeless clients with severe mental illness as the most underserved population.

In our survey of Peers and Peer Supervisors, 86.7% of supervisors and 93.2% of peers reported that there is a need for more co-occurring disorder peer programs, and even more specifically *SMI* co-occurring peer programs (fig.23).

Numerous individuals surveyed reported a severe service gap for those who are homeless with severe mental illness (SMI). Moreover, SMI populations were also identified as one of the top service gaps in the Multnomah County Peer Delivered Services Community Input Meeting, November 18, 2015.

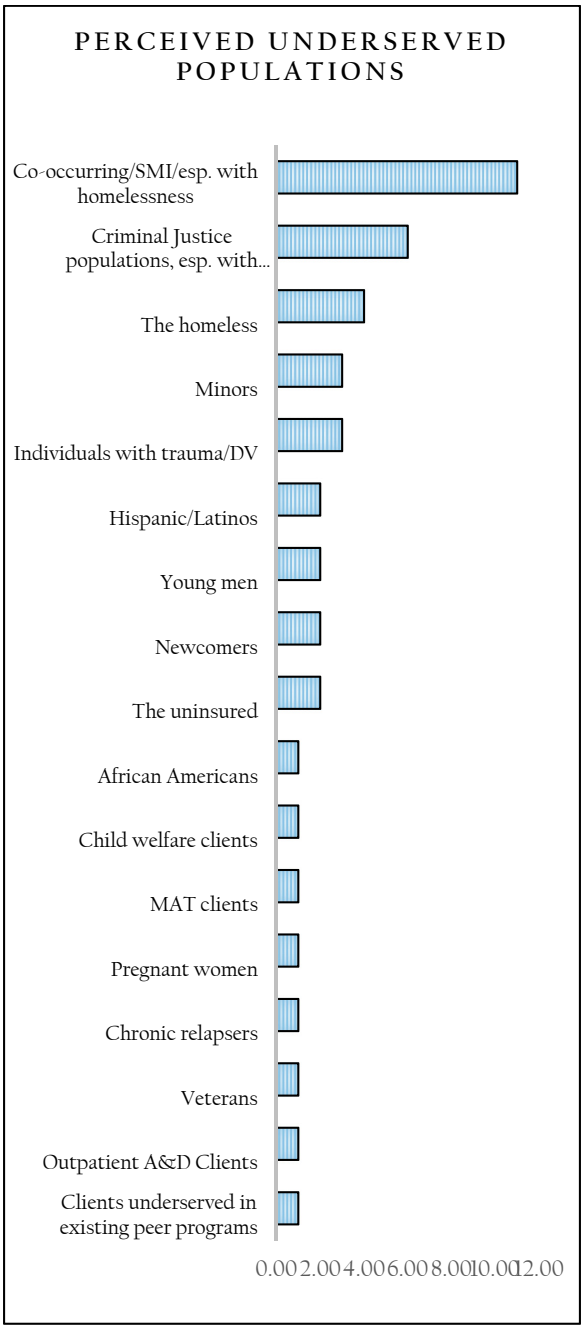


Figure 23 Supervisors and peers ranked perceptions of most underserved SUD populations in tri-counties

Supervisors and peers identify homeless individuals with severe mental illness as the greatest service gap, secondly they identified homeless criminal justice populations as most underserved.

Between 32-40% of peer program personnel report difficulty getting referrals to their programs (*fig.24*).

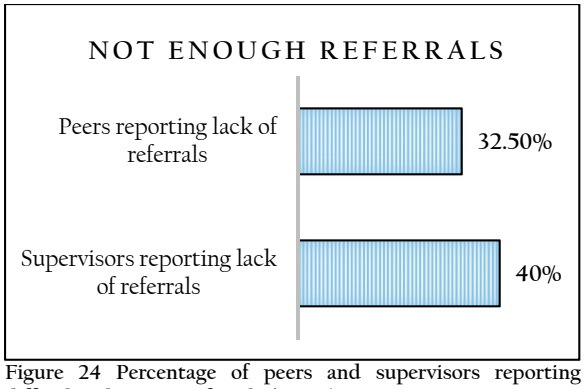


Figure 24 Percentage of peers and supervisors reporting difficulty obtaining referrals (n=124)

Corrections and A&D Treatment (corrections) are cited as the most frequent referral sources. Primary care and helplines are the least frequent referral sources (*fig.25*).

The majority of Tri-county SUD peer clients are court involved. 100% of Peer Supervisors have reported that they have had internal agency discussions regarding ways to work with primary care clients.

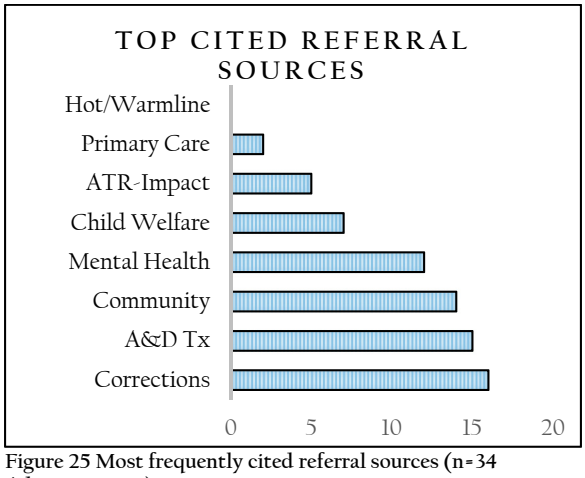


Figure 25 Most frequently cited referral sources (n=34 Administrators)

Court involved clients (corrections, A&D Tx, Child Welfare, etc.) make up the majority of the referral base for most SUD peer programs. Voluntary primary care and helpline clients make up far fewer referrals. 60% of peers report that the majority of their clients are from corrections and child welfare, compared to 40% of supervisors.

Both peers and supervisors agree that Ethics & Boundaries are the top training needs for peers.

Out of a list of 20 possible training topics, generated from interviews, discussions and a review of the literature (BRSS-TACS/White), peers and supervisors selected those they identified as the most needed. OWITS; Motivational interviewing for Peers - Basic & Advanced; Medication Assisted Treatment (Methadone, Suboxone, Vivitrol, Naltrexone, etc.); Regulations (Confidentiality, Client Rights, informed Consent, Mandatory Reporting, etc); SAMHSA Peer Competencies; Outreach & Engagement Skills; SBIRT for Peers; Person Centered Planning; 501(c)(3) Business Practices; Financial Controls, & Board Development; Involving Peers in Primary Care and Promoting Health and Wellness; Peer Delivered Services Advocacy; Peer Effectiveness, Legislation, and Marketing; Culturally Specific Peer Services & Cultural Competencies; LGBTQ/Gender Competencies; Ethics and Boundaries; Trauma Informed Peer Services; Transition Age Youth (TAY) Competencies; Older Adult Competencies; Forensic Peers Competencies; Peer Services with Veterans; Grant Writing.

48.4% peers report Motivational Interviewing Basic & Advanced as #1 training need (*fig.26*). While, 57.1% of supervisors, report Regulations (Confidentiality, Client Rights, informed Consent, Mandatory Reporting, etc) as #1 training need for peers (*fig.27*).

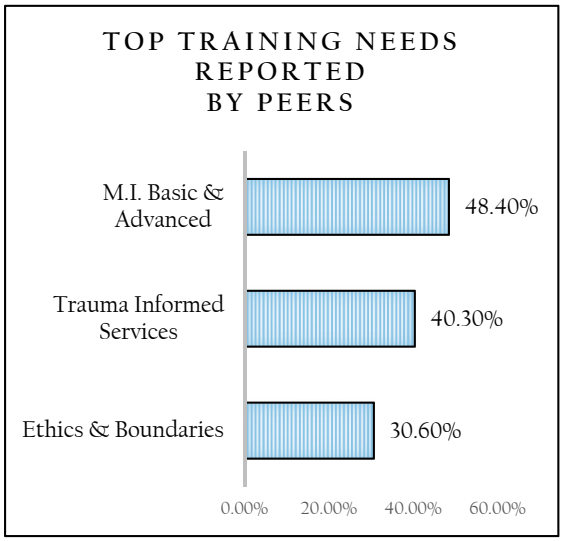


Figure 26 Top training needs for peers as reported by peers (n=124 peers and supervisors)

Figure 27 Top training needs for peers as reported by supervisors (n=124 peers and supervisors)

Peers and Peer Supervisors agree, the most serious shared concerns regarding peer competencies are: Problems with Ethics & Boundaries and Lack of awareness of Community Resources.

Out of a list of 10 possible "concerns," generated from interviews, discussions and a review of the literature (BRSS-TACS/White), peers and supervisors selected those they identified as being of greatest concern. Ethics & Boundaries, Lack of understanding of the law (Client Rights, Confidentiality, Mandatory Reporting, Non-Discrimination, Informed Consent, etc.), Client Abuse, Lack of Awareness of Community Resources, Problems working with partners like Child Welfare, Corrections, Courts/judges, Mental Health Treatment, Addictions Treatment, etc., Lack of awareness of Trauma Informed Services, Lack of Cultural/LGBTQ Competence, Lack of skills in communication and motivational enhancement, Lack of outreach and engagement skills, Lack of computer and documentation skills.

Supervisors ranked lawful behavior and regulations as their most serious concern for peers. This would include topical areas such as; Client Rights, Confidentiality, Mandatory Reporting, Non-Discrimination, Informed Consent, etc (*fig.28*).

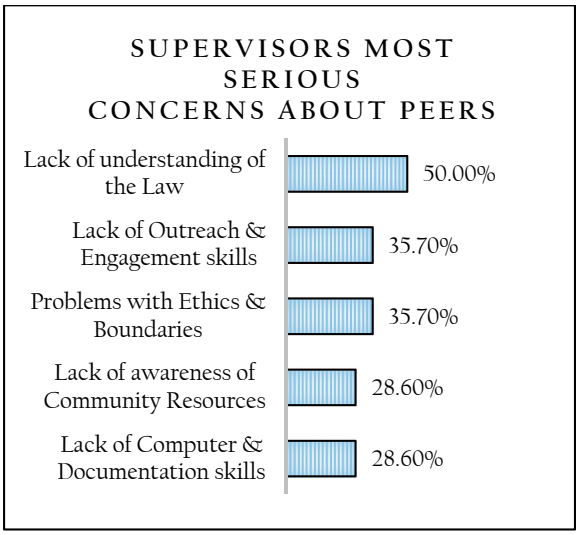


Figure 28 Supervisor most serious concerns regarding peers (n=124 peers and supervisors)

Both peers and supervisors agreed on their concerns regarding ethics & boundaries, and a lack of awareness of community resources.
Our workgroups agreed that it takes years for peers to become fully competent in their awareness of community resources. High rates of turnover in the peer field undermine this competency needed by peers.

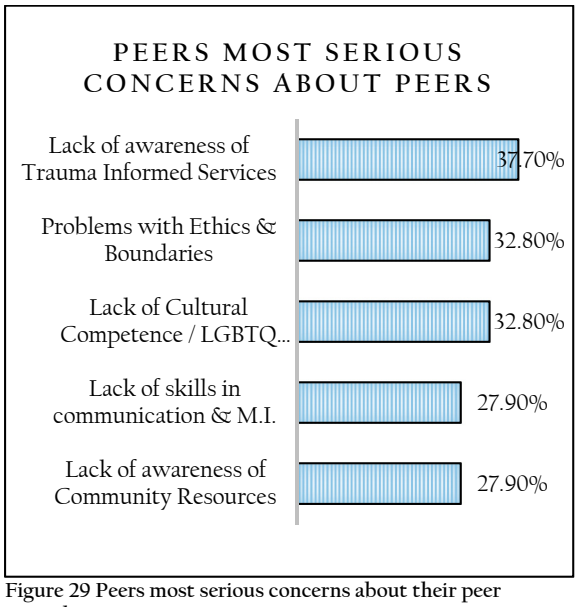


Figure 29 Peers most serious concerns about their peer coworkers

References

1. http://www.samhsa.gov/brss-tacs, http://www.williamwhitepapers.com/
2. White, W. (2009). Executive summary. Peer-based addiction recovery support: History, theory, practice, and scientific evaluation. Counselor, 10(5), 54-59.
3. Peer-based Support Services: Principles and Key Implementation Issues, 2013 SAMHSA Presentation, William L. White, MA, Emeritus Senior Research Consultant, Chestnut Health Systems.
4. The Role of Non-Traditional Health Workers in Oregon's Health Care System: Recommendations for Core Competencies and Education and Training Requirements for Community Health Workers, Peer Wellness Specialists and Personal Health Navigators, Oregon Health Policy Board Workforce Committee, Non-Traditional Health Worker Subcommittee
5. White House Report on Occupational Licensing: A Framework for Policymakers, July 2015, prepared by the Department of the Treasury Office of Economic Policy, the Council of Economic Advisers, and the Department of Labor.
6. Oregon Department of Corrections, Issue Brief, Quick Facts, 53-DOC/GECO: 3/15/1 http://www.oregon.gov/doc/OC/docs/pdf/IB-53-Quick%20Facts.pdf
7. Oregon Recidivism Analysis, November 2015, Oregon Statistical Analysis Center, Kelly Officer, http://www.oregon.gov/cjc/justicereinvestment/Documents/Recidivism_Report_Nov_2015_Final.pdf
8. White, W. (2009). Executive summary. Peer-based addiction recovery support: History, theory, practice, and scientific evaluation. Counselor, 10(5), 54-59.
9. White House Report on Occupational Licensing: A Framework for Policymakers, July 2015, prepared by the Department of the Treasury Office of Economic Policy, the Council of Economic Advisers, and the Department of Labor.
10. Substance Abuse and Mental Health Services Administration, Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
11. Substance Abuse and Mental Health Services Administration, Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-48, Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
12. Substance Abuse and Mental Health Services Administration, Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
13. U.S. Census Bureau, v2014 (http://www.census.gov/quickfacts/table/PST045215/4159000)
14. Treatment for Substance Use Disorder: Opportunities and Challenges under the Affordable Care Act, Betty Tai, Nora D. Volkow, Center for the Clinical Trials Network, National Institute on Drug Abuse, National Institutes of Health, Bethesda, Maryland, USA, Social Work in Public Health, 28:165–174, 2013, ISSN: 1937-1918 print/1937-190X online, DOI: 10.1080/19371918.2013.758
15. Peer-based Support Services: Principles and Key Implementation Issues, 2013 SAMHSA Presentation, William L. White, MA, Emeritus Senior Research Consultant, Chestnut Health Systems.
16. Veteran's Administration: VA peer support supervision survey report – 2010