EXPLORING PEER RECOVERY COACHES

REPORT ON QUALITATIVE RESEARCH

Prepared for The Foundation for Opioid Response Efforts (FORE)

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OVERVIEW

Background

The Foundation for Opioid Response Efforts (FORE) is presently engaged in efforts to explore the unique challenges, joys, and experiences of peer recovery coaches (PRCs) across the US. Through a better understanding of the PRCs' roles, this research aims to identify support opportunities for the population, as well as inform the development of a quantitative survey.

Key Objectives

The objectives of the current research are to:

- Understand the certification process of becoming a peer recovery coach, exploring barriers and opportunities to enhance the process
- Understand measures of success for peer recovery coaches
- Identify workforce challenges and barriers including, but not limited to, stigma in the workplace, peer integration into the professional team, financial compensation, and workload
- Explore nuances of the role in relation to populations served, geographic location, and workplace
- Uncover opportunities to clarify or further develop the career pathway for peer recovery coaches
- Understand the impact of the COVID-19 pandemic on peer recovery coaches and those they support

Ultimately, FORE hopes to use information gathered from this research to support the development of a quantitative survey that can be administered to understand prevalence of these experiences among PRCs in specific states and, ideally, across the US.

About the Participants / Criteria for Recruitment

Initially, SSRS conducted a two-part qualitative exploration that consisted of an online bulletin board with 31 completed participants, followed by 17 in-depth interviews (IDIs). Of the IDIs, 13 were new recruits, and 4 were reinvited participants from the online bulletin board. Each phase consisted of a mix of:

- Age
- Gender
- Ethnicity
- Geographic location
- Work setting
- Area(s) of expertise

Participants were also required to have some form of certification qualifying them to identify as a "peer recovery coach." A demographic summary of the participants in each phase can be found at the end of this report in the "Participant Demographics" section. An additional detailed participant profile has been provided separately to FORE with screener data for each individual participant.

After completing the first two phases of research, the SSRS team recommended completing additional interviews with Hispanic PRCs since among the four Hispanic PRCs that participated in Phases 1 and 2, only one felt able to speak to the unique needs of Hispanic recoverees. As a result, three additional Hispanic

bilingual PRCs were recruited and interviewed. Findings from these additional interviews can be found in the "Phase 3 Hispanic Interviews Addendum" section of this report.

Methodology

Phase 1 - Online Bulletin Board

The online bulletin board phase of this study lasted approximately one week (for three consecutive days, a new question set was unlocked for participants to engage with, followed by several days wherein all questions were visible), with each participant checking in as their schedule allowed. Once online, participants responded to pre-programmed question sets, completed exercises and activities related to their experience being a peer recovery coach, and responded to follow-up probes from the moderator, tailored to the specific responses shared by each participant. These activities used a range of techniques such as letter writing (see below for description), "blue-sky" ideations, sorting exercises, and open-ended polls to capture participant experiences and perceptions in detail.

In the first day of our research, participants were asked to describe their workplace setting, population(s) supported, and the role of the PRC within their organization. They were then asked to walk through their certification journey / training pathway to becoming a peer recovery coach, including alternative routes to certification; and explore opportunities for improvement along the certification journey. These were primarily open-ended questions.

In the second day, questions and activities were designed to: (1) uncover key drivers for becoming a peer recovery coach; (2) develop an understanding of the attitudes PRCs hold towards their role, including expectations vs. reality, pain-points, joys of the job; and (3) begin to identify opportunities to support the PRC's career pathway. To understand expectations vs. reality vis a vis their role, participants were asked to "write a letter" to their younger self discussing all the things they wished they'd known about the role, then. This encouraged participants to creatively identify and effectively communicate disconnects between their expectations of the role and their actual experiences, uncovering barriers and joys of the role that were not anticipated by the PRC before entering the field. To better understand the challenges of the role, participants were asked to write a second letter, this time "venting" to a friend about the things that make their role frustrating or difficult, along with potential solutions they wish existed. This letter-writing activity encouraged participants to more freely express frustrations and concerns about the role than they may have otherwise to uncover the intensity and significance of barriers faced. Also, within this set of questions, participants engaged in a "card sort" activity, wherein different aspects of their role (i.e., their supervisor, their own lived experience, the population they support) were listed individually on cards. Participants were instructed to drag and drop each card into one of three "buckets," entitled "Makes my job better or easier," "Makes my job worse or harder," and "Neutral – doesn't help or hurt." They were then asked to elaborate on several factors, explaining why and how each factor had the impact it did on their perception of their role.

In the third day, participants explored themes of burnout, self-care, and compassion fatigue. They were encouraged to identify ways in which others could support peer recovery coaches emotionally and professionally. Finally, participants were asked to share the effects of the COVID-19 pandemic on their ability to perform job duties, and the effects of the pandemic on their job satisfaction / confidence levels as PRCs. These were primarily open-ended questions.

Phase 2 – In-Depth Interviews (IDIs)[1]

IDIs were conducted to further explore themes, ideas, and perceptions identified in Phase 1. Each of the 17 IDIs conducted included one-on-one webcam discussions between a participant and the moderator. IDIs were 60 minutes long. Participants were prompted to zero in on the most challenging and most useful portions of their certification, as well as reflect on items that they now recognize may have been missing from their certification process, after experiencing fieldwork. Participants engaged in discussion regarding their individual workspaces, including the specific needs of the populations they support, supervisor interactions, financial implications, and the ways in which other internal and external professionals view, integrate, and utilize PRCs. Regarding populations supported, participants were prompted to discuss the ways in which their approach varies when working with specific populations (veterans, those involved in the criminal justice system, pregnant and parenting women, young adults, homeless, various genders, ethnicities, and geographic locations). Participants shared the ways in which their own recovery does or does not influence their approach in supporting others. Finally, the challenges experienced and lessons learned throughout the COVID-19 pandemic were discussed, including a nuanced conversation surrounding one main challenge identified in Phase 1: technology limitations.

Analytical Notes

Overall, participants **enthusiastically participated** in both phases of research. It was evident that many PRCs were excited to contribute to this research, several citing their **surprise and appreciation** that there is interest in understanding and supporting peer recovery coaches.

Reading Qualitative Findings

It is important to note that this research is qualitative in nature and should be used directionally. The nature of the data collection and the sample sizes **do not allow for extrapolation** of results to a larger population. The data are not necessarily representative of *all* peer recovery coaches. These findings focus on understanding *how* and *why* peer recovery coaches view their experiences, not *how many* have the same views.

The findings in this research reflect the thoughts and experiences of the participants that took part. More specifically, they represent **perceptions, awareness, and beliefs** of those involved in the study. As such, lists and ranges within this study are participant-provided and are not exhaustive (for an example, see list in "Drivers to Become a Peer Recovery Coach").

Additionally, this research was conducted during the COVID-19 pandemic, during a period when many individuals experienced increased levels of stress, and a variety of professional and personal barriers directly related to the pandemic. These peer recovery coaches reported many such instances, discussed later in this report. These findings may therefore reflect a stronger emphasis on role challenges than might occur under normal circumstances.

Terminology Preferences

This research uncovered the variations that exist among peer recovery coaches regarding titles and their meanings. Interestingly, some participants indicate that titles (as they relate to the peer recovery coaches

[1] Information about the additional IDIs with Hispanic PRCs can be found in the Phase 3 section of this report.

themselves and the groups of people they support) are **unimportant and/or interchangeable**. On the other hand, a similar portion of participants indicate that they **prefer one title over another/others**, as each carries its own implications or meanings. Three sources emerged as potential causes of this difference of opinion regarding language significance:

- **Workplace setting** – Most PRCs simply prefer to be identified as their workplace titled them.
- **Population supported** - Many prefer their title to imply congruence with the population they're supporting. Those that work with white-collar professionals, for example, may tend to prefer terms such as "specialist" whereas those supporting the homeless population can feel that even "coach" may imply superiority (which they feel is not ideal when working with these populations).
- **Certification / training level** – Those with extra training or an advanced certification seem to exhibit a slight preference for placing more emphasis on their specific title.

Titles had the following implications:

- **Peer recovery coach –** The term "peer" implies the PRC has their own lived experience with recovery. PRCs note that, while they do not believe it is required to have lived experience with recovery to become a PRC, many in this role believe a peer without lived experience should/will omit the term "peer" and simply go by "recovery coach." "Coach" carries more casual implications than some of the other titles mentioned. Almost all participants are comfortable being referred to as a peer recovery coach, though some report that, in their state, a PRC can be anyone with their own lived experience; this does not imply certification has been obtained. As the most inclusive and widely used term among the participants in this research, **this report will refer to participants as PRCs throughout.**
- **Peer support specialist –** While "peer" in this case still implies that the PRC also has lived experience with recovery, some believe the phrase "support specialist" connotes superiority to the peers (while others believe the phrase is interchangeable with "recovery coach"). For most, this superiority is not preferable, as PRCs consistently express the importance of maintaining a state of parity between peer and PRC as a means of establishing trust and rapport.
- **Certified peer recovery specialist (CPRS) –** Unsurprisingly, the addition of the word "certified" indicates an even higher level of superiority than "peer support specialist" alone, which was not favored. However, "CPRS" does refer to a specific certification that several PRCs hold, which is favored by those that have it.
- **Peer navigator –** A handful of PRCs either identify as, or wish they were called, "peer navigators." For these individuals, the term "navigator" implies they are able to help individuals traverse through recovery, "the system," and all it encompasses. It does not blatantly connote superiority; however, it is a lesser known and lesser used title, which can create some confusion among those that are already unfamiliar with PRCs.

Language to describe populations supported had the following implications:

- **Recoverees – "**Recoverees" is a term that can be described as "used by some, understood by all." Several PRCs use this term directly to describe those that they're supporting, as it feels inclusive of all populations. Even among those that did not directly utilize the term "recoveree," participants in this research understand what is meant by the phrasing. For this reason, and for clarity of this research, **this report will refer to those being supported as recoverees throughout.** However, it is important to note that even this term can be somewhat interpretive based on the varying definitions of what it means to be "in recovery," which is discussed later in this research.

- **Peers –** Many PRCs are comfortable utilizing the term "peers" to describe those they support. On one hand, "peers" works to balance the power dynamic between PRCs and those they support. However, even those that use the term note that the similarity between the titles of those providing the support and those receiving it can become confusing.
- **Clients – "**Clients" is a term used most often by PRCs that work in more clinical settings. For those that do not work in a clinical space, "client" can read as creating an uneven and unnecessary power dynamic between PRC and recoveree.
- **Guests / participants –** Used most often by those that work as part of a structured recovery program, "guests" tends to refer to recoverees in residential or partial hospitalization programs (PHP), whereas "participants" tends to encompass those in residential, PHP, and intensive outpatient programs (IOP).

Verbatim Attributions

Direct quotes used throughout this report are attributed by four key identifiers: gender, ethnicity, research phase, and population the individual mainly supports. All identifiers were self-reported by the participants during the research screening[2]. When considering the population an individual mainly supports, it is important to keep in mind that this research uncovered significant overlaps in populations supported (see section "Populations Supported"). This is to say, all peer recovery coaches in this research reported that: (1) they work with multiple populations, and (2) individuals they support often fit into multiple populations (e.g., both homeless and a veteran). Still, several PRCs were able to speak to the unique needs of the populations they work with most frequently, providing valuable insights into unmet needs and potential ways to support these individuals (also reported in the "Populations Supported" section of this research).

In summary: We recommend considering these verbatims through two lenses: (1) that peer recovery coaches support a multitude of populations simultaneously, so even if they "mainly" support one population, it is in no way exclusive, and (2) Peer recovery coaches who identified that they support a specific population most often were able to speak to some of the unique needs of that population.

EXECUTIVE SUMMARY

- A sense of **purpose and the desire to help others** is the primary driver for becoming a Peer Recovery Coach. Career growth and financial compensation are cited as additional reasons one would consider this career and consider becoming certified.
- PRCs **enjoy and value the classes** they took to become certified. However, the **process of obtaining certification can be improved on** – namely, PRCs wish there was more guidance and communication through the process of finding classes, submitting documentation for certification, and waiting for their certification to be approved.
- PRCs report **great variation in their workforce experiences,** with some feeling extremely appreciated and understood by their colleagues, and others feeling discounted and misused. PRCs have similar variation in their experiences with professionals outside their workplace, with professionals like law enforcement, physicians, and other medical professionals, some feeling as if

[2] During the screening process it was determined that many PRCs reported working with most or all of the populations asked about in the screener (at Q9). Given that, our recruiting team suggested including an additional question asking PRCs to self-identify the population they support most often. Importantly, this question does not necessarily represent how PRCs would, on their own, describe how they support different populations.

they are seen as an equal and others feeling stigmatized. **There is an opportunity to educate** professionals in a multitude of workspaces about the abilities, limitations, and best practices of PRCs.

- Financial compensation is an enticing reason to become a PRC at first – since many are already working in the recovery space in administrative roles or volunteering and **transitioning to PRC status marks a pay increase or initial compensation**. However, the **fiscal limitations of the role become a barrier** as PRCs wish to advance in their careers – PRCs are typically paid low wages and do not see a clear career path to improve this.
- For the most part, **PRCs are not supporting any one specific population** over another. In fact, most recoverees fit into multiple populations, creating **intersectional needs** for support. Though PRCs feel strongly that it is important to approach recoverees the same way (as those that need support rather than biased by aspects of their background), they identify several populations that commonly need additional layers of support, including the homeless population, pregnant and parenting women, the Hispanic Spanish-speaking populations, and rurally-based recoverees.
- For all PRCs in this study, lived experience with recovery was a major factor in their ability to support others. In discussing their lived experiences, some **PRCs spoke about their abstinence-based recovery while others indicated they pursued an all-recovery path (including MAT programs).** A few PRCs shared that they felt somewhat less comfortable supporting clients who might be on a different path in the beginning of their career, but they noted that their work in the field helped them break down these biases over time. Though challenges in light of their lived experience can emerge while supporting others, for the most part, PRCs attribute their ability to do their jobs effectively to their own lived experience with recovery.
- The **COVID-19 pandemic presented an onslaught of challenges** for PRCs, including limited access to technology and challenges in understanding technology (such as running / joining Zoom sessions, learning modern technology hardware and software, etc.) for both the PRC and the recoveree. PRCs noted that new safety regulations made it difficult to support recoverees (especially among those of a lower socioeconomic status (SES) who traditionally have less access to basic needs (such as housing, income, consistent meals, etc.), transportation, and virtual care options. As such, PRCs reported a spike in reuse, relapse, and death among recoverees. Still, some PRCs were able to **broaden their reach** through the increased use of technology through the pandemic and plan to continue integrating virtual care into their support initiatives after the pandemic is over.
- PRCs **understand how to use self-care, they just don't feel they have the time to do so**, and many are currently experiencing burnout or are at high risk for burnout. There is an opportunity for companies that employ PRCs to create a **culture of understanding** around the significance of self-care so that PRCs feel better supported in this area.

DETAILED FINDINGS

Drivers to Become a Peer Recovery Coach

For most, the decision to become a PRC is multifaceted. There are three key drivers that emerge as reasons one would pursue this career and certification:

- Purpose / helping others
- Career growth / legitimacy
- Financial compensation

Purpose

Almost all PRCs that participated in this research emphasize the sense of purpose they are able to achieve through work as a PRC. Several share that this is their **first experience** feeling a true sense of purpose. PRCs define this purpose as a **sense of meaning and accomplishment** cultivated by their ability to contribute to the very community (or an adjacent community) they themselves were/are a part of.

> *"It made me feel like all my life experiences were not going to go to waste, that I could offer hope to those still struggling." (Female, white, OLBB, mainly supports criminal justice segment)*[3]

> *"I didn't know what a PRC was until I started going through my own recovery process. Peers had helped me along the way, so I wanted to do the same. The biggest motivation was me wanting to help and the reality that this was my first job in 10 yrs. I was ready and willing to help people who were like me." (Male, white, OLBB, mainly supports young adult segment)*

Career Growth / Legitimacy

In addition to seeking purpose, many PRCs began their own recovery by participating in Narcotics Anonymous (NA), Alcoholics Anonymous (AA), or another similarly structured step-based recovery program. Within these programs, **"being of service"** is an important tenet in individual recovery. This concept encourages PRCs to find ways to contribute to society (specifically, to others that are presently struggling with addiction), in meaningful ways. As such, many PRCs find themselves volunteering or working within the **recovery space before seeking certification** (and, often, before even becoming aware that certification is an option). Certainly, others in recovery that have not gone through a 12-step program may also find themselves working in the recovery space, similarly with the intent to give back to the community.

Because many are **already working in the recovery space** (as behavioral technicians, receptionists, uncertified peers, etc.), the decision to become certified feels like a natural progression within their career path. Often, PRCs are unaware that certification is an option until a coworker, supervisor, or friend in the recovery space recommends the peer becomes certified. The decision to become certified, vs. working in the recovery space uncertified, adds a layer of legitimacy to the work they're likely already doing.

> *"I mean becoming certified…legitimizes what we do. The more recognized people in our role become the more accepted it will become. It also allows you to help others on the path as well as brings legitimacy to my name as a counselor." (Male, white, OLBB, mainly supports homeless segment)*

Financial Compensation

As previously indicated, many PRCs are already working in the recovery space in either entry level roles or through volunteer work. For these individuals, the decision to become a certified peer recovery coach, (especially among those whose employer recommended the certification) **offers a raise or a transition from unpaid work** to paid work.

> *"I handed [the company] like a binder of just character references from the girls in my group, the women in my group, and I believe that's what got them in the end, because they saw the proof was*

[3] Please see "Verbatim Attributions" section of this report above (page 8) for explanatory information regarding the identifiers used in this verbatim text and all that follow.

in the pudding. They saw the amount of people that I was helping on my free time, not getting paid for it." (Female, Hispanic, IDI, mainly supports criminal justice segment)

However, it is noteworthy that financial compensation overall is **an area of concern** for peer recovery coaches. While the initial step from unpaid to paid work offers some financial remuneration, there is a general perception among PRCs that their opportunity to advance and get higher levels of compensation is highly constrained. This finding is elaborated on later in the report. It is also crucial to consider that PRCs receiving government assistance in the form of financial compensation and/or medical benefits fear losing these benefits when taking on a role as a PRC. Unfortunately, many PRC roles in the US are described as low paying and part-time (without benefits) which presents a significant hurdle for PRCs when deciding to continue with the work long-term.

The Certification Journey

Overarchingly, **PRCs report satisfaction** with the curriculum and interpersonal experiences throughout their certification journey, while still identifying a few **opportunities to improve** the process. When PRCs in Phase 1 of this research were asked "how easy or difficult the certification process felt, overall," roughly two thirds felt that the process was "mostly easy" or "very easy." Among all PRCs in this phase, including those that felt the process was "mostly difficult" or "very difficult," the following hurdles were cited most:

- Difficulty making time for required classes and field work
- Lack of clarity surrounding procedural steps to become certified
- Difficulty finding classes / opportunities for field work
- Testing anxiety

"Having to jump through hoops to get certified while making a very low wage as a peer was very stressful and there was a lack of direction on how to actually make the process happen." (Male, white, OLBB, mainly supports criminal justice segment)

"It made me feel excited to be provided with trainings around motivational interviewing. It was also very fulfilling to be able support people on any pathway to recovery. I started to value the idea that connection is a huge factor in outcomes." (Male, white, OLBB, mainly supports criminal justice segment)

Variations Among Programs

Most peers do not do research to compare certification programs / certification options before enrolling in a program. In fact, many believe there are not multiple options for certification within their state. Most often, peers are encouraged or required by the recovery site they're **already a part of** (as an employee, recoveree themselves, or volunteer) to obtain certification. In these cases, the recommending / requiring organization often **selects the program the PRC will attend and pays for the training**. In cases when a PRC discovered the certification without the help of an employer / recovery site, this mainly occurs through word-of-mouth recommendations from other recoverees that have engaged in a certification program.

Though several certification programs were mentioned, PRCs name the Recovery Coach Academy (RCA) more often than any other certification program. According to the RCA website, the program is nationally recognized and a leading program for PRCs worldwide. This program is developed and managed by the Connecticut Community for Addiction Recovery (CCAR), but is not limited to those in Connecticut, and is available to complete online (https://addictionrecoverytraining.org/). Additionally, some PRCs express awareness of or hold a state certification and a national certification.

PRCs report a wide variety of required training hours within their programs depending on the certification program they've selected and the state in which they are becoming certified. Ranges reported are as follows:

- **Base certification classes** - A single webinar (roughly 25 minutes) to 136 hours of class time. This portion can take anywhere from days to months, depending on how classes are structured. For example, some PRCs report attending a full week of classes, 8 hours per day, while others report attending classes only on Saturdays for a longer stretch of time.
- **Fieldwork hours** - 200 - 900 hours of fieldwork that may include, but is not limited to, volunteer work, direct recoveree support hours, and supervision.
- **Additional certifications / trainings** – 16 - 20 hours per additional course. The most mentioned "extra" training by PRCs is ethics training, which some indicate is optional and others indicate is actually an additional requirement to obtain base certification. This discrepancy may be due to awareness and/or state and program nuances.

  "So, the "certification" process here in [West Virginia] to be able to bill Medicaid is a complete joke. As I have already mentioned, we are moving towards a better certification process but that is still a year or so away for it to be mandatory. As of right now in the state of [West Virginia] all a person has to do to be a PRSS [Peer Recovery Support Specialist] is have 2 years in recovery, pass a [West Virginia] Cares background check (if they don't pass they can file a variance), and then watch a 25 minute webinar on the DHHRs website. So that's 25 minutes for the webinar, 10 minutes for the background check (it comes back in a day or so) and 2 years of Recovery under your belt. I personally think this process is a complete joke and does NOT adequately prepare someone to be a PRSS." (Female, white, OLBB, mainly supports homeless segment)

  "Becoming a CPS [Certified Peer Specialist] was challenging; it took over four years to finally get accepted." (Female, black, OLBB, mainly supports veteran segment)

Successful Components

Successful elements of the certification process include:

- **Cohort benefits –** PRCs reflect fondly on their time in training, largely due to the presence of their peers. PRCs mention that learning alongside others seeking the same certification and career (mostly with their own lived experiences in recovery) creates a bonding, supportive environment that improves the overall experience.
- **Content learned** – Most PRCs feel confident that the certification content contained everything needed to begin as a PRC in the field. Unaided, many were not able to identify content lacking from the lessons. However, when prompted, PRCs did acknowledge some area for content enhancements (see "Opportunities to Improve" below). Interestingly, the most valuable content reported among many PRCs is ethics training, which some PRCs believe is not a mandatory component of the training.
- **Ease of completion** – Most PRCs agree that completing the courses / lessons themselves was fairly easy in terms of content, although most feel they nonetheless learned everything they need to know. Any opportunities for improvement in this area appear to stem from external factors, such as needing time off from work to complete the courses (more on this below).

  "It made me feel excited to be provided with trainings around motivational interviewing. It was also very fulfilling to be able support people on any pathway to recovery. I started to value the idea that connection is a huge factor in outcomes." (Male, white, OLBB, mainly supports criminal justice segment)

"I felt empowered as I attended trainings and learned more about addiction- and recovery-oriented systems of care. As a family member, it was important for me to feel I could help someone else along their journey." (Female, white, OLBB, mainly supports criminal justice segment)

Opportunities to Improve

- **Process navigation –** The most cited area for improvement among all PRCs in this research is process clarity. Many PRCs weren't sure of each step in the process of becoming certified, from registering / enrolling in classes through obtaining certification, and they weren't sure where to turn to for answers to these questions. When prompted, PRCs responded very positively to the idea of a designated person, or even a checklist, to help them understand each step in the process. Additionally, access to a contact person or trusted resource to advise PRCs on details related to their specific "next steps," as certification programs may differ, is desirable.
- **Certification Processing Time –** PRCs report two ways in which certification processing is problematic. First, PRCs state that the length of time it takes between steps (e.g., waiting for a testing date to open up, waiting to receive certification after completing requirements, etc.) can add several months to the overall journey. Second, PRCs report that communication is lacking throughout this process. So, not only can the process be lengthy, but they're also left with little visibility regarding the status of each step, making this one of the most frustrating parts of the journey.
- **Support through personal hurdles/Test-taking anxiety –** Though several PRCs noted this is not the fault of their certification program, they still struggled with personal limitations which made the certification process more difficult to complete. Personal limitations included the hourly commitment to certification / fieldwork (especially among those that had consecutive, daily training and may have needed to take off work, arrange for childcare, etc.) and testing anxiety surrounding the certification exam. Flexibility in program completion options and additional test preparation may help PRCs feel more supported through the process.
- **Content development through peer involvement –** Though most felt that the content of the lessons was comprehensive, PRCs did have additional ideas for how to further enhance the curriculum. Several identified that the curriculum, while foundational, can feel somewhat disconnected from the actual application. To resolve, PRCs recommend that peers be more involved in the curation of the curriculum, informing trainers (who may or may not be peers themselves) of relevant topics that need to be addressed in the curriculum. In Phase 2 IDIs, PRCs were asked, "now that you're in the field, is there anything you'd want to see added to the curriculum that would have made it better / could make it better for incoming PRCs?" When prompted this way, PRCs noted that emphasis on a few items could enhance certification content:
    - **Population-specific training** (especially among those that serve pregnant and parenting women, discussed further in the "Populations Supported" section of this report)
    - **Technology training** (hardware and software)
    - **Business basics / entrepreneurial skills** (especially among those who independently contract and are building their own client base)
    - **Increased cultural competency** (though most PRCs reported that they, themselves felt culturally competent, they suggested this for other PRCs)

"[I wish it was an] overall-smoother process. It was difficult to navigate, disorganized and frustrating. Ideally - lay out the process, make it simple to navigate but deep in content. Please use peers to develop the process. Speak our language and keep recovery a value. I often find that non-peers are

doing a lot of decision making in these processes and providing the training…and that's frustrating, annoying and not effective." (Female, white, OLBB, mainly supports criminal justice segment)

"I had to learn how to work a computer - I have been out of school since 1973 so taking a course was scary at first." (Male, black, OLBB, mainly supports veteran segment)

Securing Employment

As discussed, most PRCs involved in this research were already working, recovering, or volunteering at the site that ultimately recommended / required (and paid for) their certification. As such, many report that it was **not difficult to secure employment** in the field. However, among those that were not working in the recovery space before employment, some difficulty was reported. PRCs that elected to become certified without an employer's recommendation shared that finding a job can be **challenging if they don't have "connections"** to help along the way.

"It was easy to get a job…a friend recommended me to my job now." (Male, Hispanic, OLBB, primarily supports young adult segment)

"So [I got certified and] I sat on it for a few years [because there were no job openings]. You really have to have like a heart and a passion for harm-reduction to kind of go down that road. It was like, I just was getting kind of discouraged…then within a year…[the company I'm with now] called and said, 'So we're hiring for a peer. We finally got some funding.' I was like, 'Yeah, I'll take it.' (Female, white, IDI, mainly supports criminal justice segment)

Workforce Experiences

There is **high variety** among PRCs when it comes to their experiences in the workforce. Some feel mostly stigmatized, underappreciated, and underutilized or incorrectly utilized. Others feel mostly valued, supported, and well-integrated into their teams. There are a multitude of factors that influence these varying experiences, including supervisor recognition, the work team's understanding of peer services, and career stability / opportunities for growth.

PRCs face a **unique set of potential barriers and challenges** as they consider continuing their work in the recovery space. Upward mobility, financial compensation, and job security are mentioned as hurdles significant enough to consider a **career change**.

Role Clarification

Role clarification is a layered topic for PRCs. There are several points of consideration when discussing role clarity including: (1) how clear the role is **to the PRC**, themselves; (2) how clear the role is **to other professionals;** and (3) how aspects of **role ambiguity** may be embraced vs. unsettling or frustrating to PRCs.

For the most part, PRCs report they have a **clear understanding** of what is ethical, as outlined by their certification courses, and what is acceptable and required of them, as outlined by their employer. However, PRCs share that there is flexibility within these outlines allowing for ways they can support clients that are not available to other support personnel (such as clinicians) on the team. PRCs most often cite the **ability to transport recoverees in their vehicles** and the **ability to self-disclose** frequently as key variations between the PRC role and the clinical role (i.e., a counselor, a caseworker, etc.).

PRCs also acknowledge mixed feelings associated with the fact that boundaries are not as black and white as they are for clinicians, and that they need to be self-governing when it comes to setting boundaries with recoverees. Most saw **great value in the flexibility**. PRCs consistently reported that the ability to set their own boundaries, be flexible, and utilize their own discretion allows them to **build invaluable rapport** with recoverees that clinicians may be less able to develop. This, in many cases, is believed by PRCs to be a source of trust between PRC and recoveree, which serves as the foundation that allows PRCs to be **true advocates** for recoverees. This is especially true in cases when recoverees may be less trusting of other professionals. Notably, however, a handful of PRCs also identified challenges in this role ambiguity (for example, one was not sure which encounters they could and could not bill for, and a few mentioned they had compromised their boundaries in the past).

> *"But it's almost where there's no law, there's no sin [when it comes to boundaries]. So even though I don't know, I can always advocate for [pushing] a certain boundary or a certain limitation." (Male, black, IDI, primarily supports homeless segment)*

> *"No one has ever given me any rules about what I can and cannot share. I definitely know that there are multiple pathways to recovery and that everyone recovers differently. So, I am careful when/how I share my pathway to not influence or press it on someone. I've never even thought about this question until now." (Female, white, OLBB, primarily supports homeless segment)*

Importantly, many PRCs feel that **other professionals (within their organizations and externally) don't fully understand the PRC's role**, responsibility, and abilities. For PRCs, this is evidenced by the fact that they're frequently asked by those inside their organizations to perform duties outside their scope of training and, often, these asks can feel menial to PRCs and do not capitalize on the specialty knowledge and experience a PRC brings to the table. Professionals outside the PRC's organization may have even less of an understanding of the role and may conflate a PRC with a sponsor. PRCs report that it is often up to them to advocate for themselves and set clear boundaries with fellow professionals when it comes to what a PRC can and should do to support recoverees and their organization.

One of the **greatest areas for opportunity** discussed in this research is the **need for education** amongst professionals regarding the role of a PRC. PRCs believe that said education would be highly beneficial for:

- **Organizations that are potential employment spaces for PRCs** – For these organizations, education would include spreading awareness that PRCs exist, highlighting ways they could improve the organization, and identifying potential funding options for bringing PRCs onto the team.
- **Organizations that already have PRCs on their team** – For these groups, education can be more specific, refreshing coworkers on the intended function of a PRC, outlining best practices for integrating them into the team, and even providing an overview of the things PRCs learned in their certification course to give others more comprehensive knowledge of their skillset.

> *"There's definitely a stigma. There's also, all my peers that work there saw me as a tech, so oftentimes they would be like, "Hey, can you tell this guy he needs to make his bed?" And I'm like, "No, no, actually, we're just friends. I have no power over him." And they had a really hard time understanding that." (Male, white, IDI, mainly supports young adult segment)*

> *"Now, I feel [like other professionals respect me], only because I have an [official county] badge, because that makes me like, the same person signs the police officers' checks signs mine…before [I had the badge, it was like], 'Well, who are you again?'." (Male, black, IDI, mainly supports criminal justice segment)*

Team Inclusion

According to PRCs, there is **ample opportunity to better integrate PRCs** into the workplace / recovery team at most sites. Fortunately, there are also a few standout examples in how to do this effectively. Many of the opportunities for team inclusion that PRCs identify clearly begin with **increased education** for the team and other professionals about what exactly a PRC does and is capable of doing, as outlined above. Following education, many PRCs hope to be **seen as specialists** in their field, with their differentiating qualities being **lived experience and relatability**.

Among the most satisfied PRCs, many report that their sites are **already doing this effectively**. According to PRCs, a handful of organizations have already begun education efforts, inviting the PRC themselves or an external training provider to hold an educational seminar for the entire site or the recovery team. In one case, the PRC decided to take matters into their own hands after becoming inundated with entry-level and unrelated work to create a training for their team. This PRC reported significant improvement in the alignment between work assigned and their expertise as a result.

Other satisfied PRCs report that their team views them as a specialist, evidenced by a **high level of trust in the PRCs actions, decisions, and input**. Interestingly, in our research this "specialist" view was reported on in the following (seemingly opposite) instances:

- **First on the team** – In some cases, being the first PRC on the team represents an opportunity for the PRC and the recovery team to define the role as it fits for them, allowing the PRC to have input into the role development. It is also likely that the organization applied for a grant, or otherwise actively sought ways to bring a PRC onto their team (instead of merely inheriting PRCs). This creates a sense of value surrounding the PRC and what they can potentially bring to the table, resulting in the PRC feeling appreciated and well-integrated.
- **One of many** – On the other hand, PRCs that join a team already comprised of several other PRCs may benefit from the structure and precedent that has already been developed at the organization. Those that work with 10 or more other PRCs report feeling valued and understood by their team likely because these teams can have equal parts PRCs to other professionals, if not more PRCs. In these cases, PRCs may have the benefit of being a majority voice, and also report feeling like the "backbone" of the organization.

  "I enjoy [being the only PRC] …I'm everywhere as far as everyone looks for me to do a two-people job for the most part, and I just give them 100%. I do that best that I can and I'm doing pretty well to be only one peer." (Female, black, IDI, mainly supports criminal justice segment)

  "So, us [PRCs] working together in our meet-ups in our community and our recovery community really strengthens the foundation of our role. This is my practice. I consider myself a practitioner." (Female, black, IDI mainly supports homeless segment)

In summary, it appears that those feeling the highest levels of team inclusion are employed by an organization in which the team **exhibits appreciation** for the PRC and **proves this appreciation** by looking to the PRC as an equal member of the recovery team. This is done through efforts to understand the PRC's role, efforts to include the PRC in role development, and an overall respect for the PRC as a specialist.

Peer Supervisors

The peer supervisor can play a significant role in whether a PRC feels valued and understood within their organization. Generally, PRCs feel better understood and appreciated by supervisors who are **in recovery themselves** *or* have **undergone their own training** / sought out education to fully comprehend the roles,

abilities, and responsibilities of PRCs. Many PRCs that do not have a supervisor either in recovery, trained as a PRC themselves, or with some education as to what a PRC report feeling **less overall support and appreciation** in the workplace. The exception to this occurs when the supervisor allows the PRC to be **autonomous**. In these cases, the distance between supervisor and PRC is interpreted as **a sense of trust** in the PRC to handle their role and responsibilities on their own.

Some PRCs report that they couldn't imagine having a supervisor that wasn't themselves in recovery / hadn't undergone some level of PRC training, and they imagine the lack of understanding would create a **noticeable disconnect** between the PRC and the supervisor in terms of how well the supervisor understood the role of the PRC (and potentially, between the PRC and the rest of the team).

> *"Even my supervisor is in recovery… yeah, I have a great supervisor. We went from [recovery] to this program together. So, she knows me, you know what I mean? And she knows my stance, and she knows my background, and she knows I'm for the people. So, she advocates for me a lot." (Female, Hispanic, IDI, mainly supports criminal justice segment)*

Additionally, the happiest PRCs report that their **supervisor is capable of celebrating "small victories"** with them. Several PRCs share that their supervisor may have concrete benchmarks or metrics of success to reach (often implemented by the organization or their grant contract), which can deter supervisors from recognizing the less tangible wins. This can create an unfortunate disconnect, being that PRCs find the bulk of wins and successes in these less tangible wins. For example, many PRCs share that "wins" for them include a recoveree reaching out for help after a relapse, regaining custody of visitation with their children, or refraining from substance use for one more day. Those with supervisors who also recognize these as wins feel **appreciated and successful**, where those with supervisors more focused on meeting metrics feel **less supported by their organization and less impactful, overall**.

Professional Perceptions of PRCs

As advocates and "resource brokers" (a term PRCs use to describe the function of their role that requires connecting recoverees to various community resources), PRCs often come into contact with professionals outside their organizations including, but not limited to, law enforcement, medical professionals, case managers, and child protective services. Unfortunately, many PRCs **do not feel well-received** by professionals outside of their organizations, largely due to **stigma**. PRCs express that they sense other professionals are treating them as an "addict first" and not as a true equal or fellow professional. Many PRCs suspect that this, too, is a result of **insufficient education among other professionals** and the general public regarding what a PRC does. Education efforts in these spaces have the potential to reduce stigma for PRCs when attempting to advocate for their recoverees, and this education may lead to an increased desire to establish or expand PRC roles in these organizations.

Several PRCs reported different experiences, sharing that they **do feel respected** among other professionals. In these cases, PRCs expressed that things such as a badge provided by their organization or a seemingly more professional title (such as Certified Peer Recovery Specialist) may influence the way other professionals perceive PRCs.

> *"Stigma surrounding people who use drugs or people in recovery from a substance use disorder is something that is very challenging and creates so many barriers for folks- especially early in recovery. I have seen so many professionals, including doctors, nurses, social workers, pharmacists, and many more, treat my clients differently just because they use drugs. They even treat me differently because sometimes I don't wear my badge if I accompany someone to the doctor for confidentiality reasons and they will treat me like I am a friend or someone with them who also uses drugs and so I'll have*

to hand them my business card and their demeanor instantly changes." (Male, white, OLBB, mainly supports criminal justice segment)

"I feel like some of them do [respect us] and the others I don't. I do feel like sometimes they think they're above us." (Female, Hispanic, IDI, mainly supports criminal justice segment)

The Career Ladder & Financial Opportunities

Career advancement and financial compensation represent two of the major concerns PRCs have about remaining in the role long-term. In our research, three factors emerged for PRCs as they consider whether or not they see themselves in the role permanently:

- **Advancement opportunities** – Many PRCs, like other professionals, naturally want to progress forward in their careers for both financial gain and personal growth. However, PRCs note that there is no clear career pipeline for them after becoming a peer supervisor (and for some, this is not a desirable "step up" as the job may become more about supporting other PRCs than it is about supporting recoverees). As such, many feel the next "promotional" step is to seek additional certification and/or formal education to gain the qualifications to move into another recovery- or mental health-oriented position. Several identify their next step as becoming a Certified Drug and Alcohol Counselor (CADC) or a Substance Abuse Counselor (SAC). Those that do not plan to obtain more formal education aren't totally sure of next steps, which can leave them feeling vulnerable and without a clear path forward.
- **Financial compensation** – Almost all PRCs who participated in this research report receiving relatively low wages that, for some, create a slew of personal hurdles. Many PRCs discuss earning $13-$15 per hour and may not be in full-time roles. Those that are earning $30,000 or more per year tend to consider themselves among the better-paid in the industry, which many PRCs believe is still below the average most other healthcare workers in their state make. Besides the low morale and increased feelings of burnout (more on this in the "Self-care & Burnout" section of this report) that can occur as a result of these wages, several PRCs are also facing unstable living situations. As one could imagine, the fear over being unable to secure basic needs, such as housing, can take a toll on any professional (or person, for that matter). PRCs also recognize that there is not much opportunity for financial increases throughout their career should they remain PRCs, and the lack of financial opportunities can create a feeling of stagnation in the role. While the primary drivers for PRCs to remain in their role, again, are the intangibles (e.g., a sense of purpose, helping others through the recovery process, etc.), most still hope/need the opportunity for financial increase as they develop professionally.
- **Job security** – Many PRCs worry about the longevity of their positions, especially among those that know they're grant-funded. For these individuals, they know there's an "expiration date" on their position, creating a sense of insecurity. PRCs that are not feeling valued or well-integrated in the organizations tend to see themselves as the most expendable employees at their sites, despite the meaningful direct-care they provide. Those experiencing low levels of job security may begin to seek employment that feels more stable, even before the actual threat of job loss emerges.

  "I don't know [if I can afford to stay in this role]. I really don't. I don't know if going forward I had to think about myself and I have to think about my family and being able to care for myself. And so, if I can go back to school and get a bigger paycheck, then I might have to do that. Even though to be fair, I love my job. And I really don't want to change." (Female, white, IDI, mainly supports homeless segment)

"[Being grant-based is] a little nerve wracking. There are times that I say to myself, 'I probably should get back into school'… just because that fear does come up. I guess I just enjoy my job so much that I kind of just keep going and doing what I'm doing." (Female, white, IDI, mainly supports criminal justice segment)

Summarized Opportunities to Support

Overall, PRCs have many of the same needs any professional has: job security, financial and career development opportunities, and a desire for equal treatment among other professionals. In addition to this, PRCs face the added challenge that many organizations, professionals, and the general public simply have low awareness and low education regarding the role and capabilities of a PRC. In short, PRCs identify that it is difficult to feel appreciated when many don't know they exist or what they do (and in some cases, approach them through a stigmatic lens). Across the board, PRCs agree that **increased education for others** is a desirable and worthwhile solution.

Populations Supported

The Role of Intersectionality

In both phases of the research, PRCs were encouraged to describe the groups of people they support. In each phase, PRCs **did not naturally group populations** into the segments identified before entering the study (which included veterans, homeless, those in the criminal justice system, young adults, pregnant and parenting women, those in rural and urban settings, and across a multitude of ethnicities). Instead, many responded to the question that they support "people with addictions" or "people in recovery." In Phase 2 during the IDIs, we included specific probes regarding how PRCs worked with different population segments. They reported that they are trained and naturally inclined (many due to their own experience with recovery) to **approach supporting everyone the same** -- recoverees are viewed as those seeking support first, and by population second, if at all. Primarily, this is due to the fact that PRCs are specifically trained to "meet people where they're at" and join with them in their recovery journey. In fact, some PRCs note that this is a **key differentiator between a PRC and a counselor**. The implication is that a counselor's training may encompass / focus on earlier life experiences to identify root causes, whereas a PRC's training is more oriented towards the present moment and path forward. As such, PRCs tend to focus on an individual recoverees' needs, regardless of the population they're a part of. PRCs are **not aware of any specific training** in working with select populations, and, as a result, none in this research participated in population-specific training.

Once offered population-specific language, interestingly, the PRCs that took part in this research reported that they **do not work exclusively with any populations**. This is to say, each PRC is likely to be working with a multitude of populations, many of which overlap. For example, several PRCs who work with the homeless population also noted that their homeless recoverees may also be involved in the criminal justice system or may also be veterans. Understandably, recoverees that represent overlapping populations can have **complex needs**, wherein the PRC will need to identify resources that speak to each recoveree's unique hierarchy of needs. For example, an individual that is homeless, actively using, and in a rural area may present the PRC with the challenge of locating a shelter that offers clean use kits or accepts those that are using in an area where resources may be sparse and public transportation is less abundant. This would require addressing a very **different set of needs** than, say, an abstinent recoveree with secure housing in an urban setting.

Population-Specific Needs

Several PRCs were able to identify that, despite their approach being the same for everyone, some needs do, in fact, emerge more frequently or manifest in different ways among specific populations. Populations that appear to most frequently require specific resources are as follows:

- **Homeless** – Those that work with the homeless population identified that these individuals are not having basic needs met and often need assistance securing housing, fiscal resources, clothing, and food before or alongside recovery assistance. In receiving recovery assistance, the homeless population may also need additional support with technology resources (devices and training) and transportation. Not surprisingly, this group overlaps with other population segments of interest to FORE, notably those involved in the criminal justice system and veterans.

  "One of the biggest challenges with all of the individuals I work with is trying to find appropriate housing resources for them. The most rewarding thing about working with individuals is seeing the pure joy and excitement when they achieve a milestone or have a success- either big or small- and seeing their happiness." (Male, white, OLBB, mainly supports criminal justice segment)

- **Pregnant and Parenting Women** – PRCs (some of whom were able to speak to their personal experience as a pregnant woman in recovery) observed that pregnant and parenting women in recovery are likely to experience stigma more so than other groups. Pregnant women often face or fear facing harsher judgement and repercussions from medical professionals and child protective services. PRCs report that many pregnant recoverees are experiencing high levels of anxiety over the well-being of their developing child, alongside the concerns many recoverees already have about their own well-being. Additionally, many pregnant and parenting women, according to PRCs, experience concerns over the future of their children and their parental rights regarding state / CPS involvement. Many pregnant and parenting women are concerned that, by seeking recovery services, medical intervention, or even attending their OBGYN appointments, they'll open the door to state involvement and, potentially, lose their parental rights. As such, PRCs report that pregnant and parenting women may need mental health support and advocacy even more than recoverees in other populations.

  "It's funny that you mentioned pregnant women because it is law in Virginia, and I don't know whether it's like this everywhere. I really hope it's not. If I am pregnant and I am on medication assisted treatment, I'm automatically connected to child protective services." (Female, white, IDI, mainly supports homeless segment)

- **Hispanic / Spanish-speaking** – Within both phases of this study, a total of four respondents identified as Hispanic, despite efforts to recruit a larger sample of Hispanic PRCs. Of those respondents, only one was able to report on differences in the needs of Hispanic recoverees vs. recoverees of different ethnicities. This PRC, who is also the only bilingual Hispanic across both phases of research, discussed the need for more diversity among PRCs, specifically noting the need for more bilingual PRCs. This individual noted that, beyond the lack of Spanish-speaking PRCs, there is a lack of community resources to support ESL or monolingual Spanish-speaking recoverees, making it difficult for Spanish-speaking PRCs to make referrals and broker resources for their Spanish-speaking recoverees. Though this information comes from a single source (N=1), it is supported by the difficulty our team experienced identifying and recruiting Hispanic PRCs for the research.

"So, that's another big barrier for the people that I deal with…a lot of them, when they make the appointment, especially the two that don't speak any English, one is applying for social security… so, every time he gets paperwork, he's calling me, 'Can you come and help me fill out here a paperwork?' I'm like, 'Yep. I'll be right over.' Because they don't have nobody. They need people [that speak the language]." (Female, Hispanic, IDI, mainly supports criminal justice segment)

- **Rural Area Residents** – PRCs offering support in rural areas note that there is less access to resources, specifically public transportation, in these areas vs. in an urban setting. In addition to resources being scarcer, PRCs report that there is also a high risk of relapse with fewer opportunities to engage in recovery support and recreational activities. To put it simply, where there is less to do, it becomes more important that recoverees find alternate forms of entertainment, socialization, engagement, etc., to help avoid relapse or reuse – and these are less available in rural areas.

  "It is pretty rural. … I would say, but we definitely still struggle with transportation [and] all of that." (Female, white, IDI, mainly supports criminal justice segment)

  "If this place wasn't here, where would they have gone? Where I'm at is, it's rural…so when you're in a rural area, there's no one. [Which] can cause people to get back into their old ways of habit." (Female, black, IDI, mainly supports criminal justice segment)

Integration of Personal Recovery

Most PRCs share their personal recovery stories openly, which may be due in part to the nature of their work. PRCs report that **their own lived experience with recovery is the single most significant factor in their ability to support others effectively**. Even among PRCs with formal education, and among those that value their certification courses, it is evident that PRCs feel best equipped to navigate others through recovery based on their own journey and understanding of the experience. They also express that their roles require self-disclosure regularly to create connection and relatability with their recoverees. However, PRCs note that **they do not approach supporting their recoverees through the lens of their own recovery**. As previously mentioned, PRCs express that their training requires them to approach each person seeking recovery without bias, and this includes ensuring their own recovery doesn't influence the way in which they're supporting others.

Additionally, PRCs report that they do not feel "triggered" by recoverees that have similar stories to theirs, whether it be similar life experiences, drug of choice (DOC), etc. In fact, **PRCs feel best equipped to help those they can relate to** and aim to find ways to relate to all kinds of recoverees if they believe their shared experiences will aide in their recovery.

There are some nuances, however. The standout variation in personal recovery as it applies to supporting others lies in the abstinence vs. all-recovery approach. For the most part, 12-step meetings and similar programs tend to be associated with an abstinence-based recovery path. In contrast, an all-recovery path may encompass those that are on medication-assisted treatment (MAT) such as Methadone or Suboxone. Additionally, some PRCs discussed those utilizing harm-reduction methods, which can include continued utilization of some substances, with the goals being safer use and use reduction through safe-use kits, safe-use spaces, etc.

Notably, a handful of PRCs shared that they are currently on MAT and intend to continue this plan, as it has been effective for them. This can be an emotional topic for those participating in all-recovery methods. Among those on MAT, there are concerns that others (i.e., the general public, some clinicians, and others in recovery) may not view them as truly "in recovery" and may view them as "still using," which, unsurprisingly,

can feel disheartening. Those that found success in abstinence note that working at an organization or supporting recoverees on an all-recovery approach can be challenging at first and require them to confront biases they may have held about safe use or MAT. Likewise, those on all-recovery paths themselves (many of whom did not have success with 12-step meetings / abstinence) report needing to set aside their personal beliefs to support recoverees with a desire to participate in a 12-step program or seek abstinence. Though some PRCs reported that this can be challenging in the beginning, almost all found that it became easier and more natural through experience supporting recoverees on all paths, from all backgrounds.

> *"Operating in the realm of supporting patients across the entire spectrum from abstinence to chaotic use is a tricky place and through motivational interviewing we let the patients decide what they want to do and what they believe will work for them. My own chosen pathway is not at the forefront of the way I care for the participants I engage with. I only talk about the 12-steps when asked about my personal journey." (Male, white, OLBB, mainly supports criminal justice segment)*

> *"But I guess with the [different] approaches...[I'm] trying to be more open-minded. All because my recovery looked like this...and just kind of like learning that I can start off talking about, 'Well, this is what happened with me.' It really helped. And the biggest thing was to just take my opinions out of it. It's kind of like what you said in the beginning about biases." (Male, white, IDI, mainly supports criminal justice segment)*

> *"I'm one of the only people where I work [that] is on MAT medication. I've been on it for 10 years and absolutely saved my life... I tried everything [including] abstinence-based. I've been to 27 inpatient rehabs...you name it, I've done it. I tried everything...but working, especially breaking that stigma in the field, it's not always easy. People look at you like you're not really in recovery...I feel like I'm all about the harm-reduction approach. People are dropping dead it's just about keeping people alive at this point." (Female, Hispanic, IDI, mainly supports criminal justice segment).*

Opportunities to Support

While many PRCs pride themselves on the ability to serve multiple populations equally and without bias, it is also evident that many PRCs would benefit from **population-specific resources and training**, especially within those populations outlined above. When prompted, almost all PRCs responded positively to the idea of population-specific training with a focus on how to best support those within said community, complete with resources they can offer to their recoverees.

COVID-19 Implications

The pandemic has been challenging for many, including PRCs. PRCs continue to face many complications as a result of the pandemic, mainly related to **new limitations in supports they're able to offer their recoverees.** A particularly saddening and disheartening outcome of the pandemic has been the **increase in relapse or reuse, overdoses, and deaths** PRCs have witnessed among recoverees. PRCs express that this is likely due to the combination of **increased fear and stress** directly related to COVID and the isolation / **inability to seek help** via in-person supports.

In Phase 1, PRCs who participated in the OLBB were asked to report "how confident they feel overall in their ability to perform their job" and, separately, were asked to report "how confident they feel in their ability to perform their job during the pandemic," with each question on a 1 to 10 scale, where 10 represented the highest level of confidence. **Average confidence dropped when reflecting on their confidence during the pandemic**, with 28 participants out of 31 (90%) choosing 8, 9, or 10 to represent their overall confidence

level, and only 21 participants (68%) choosing 8, 9, or 10 to represent their confidence through the pandemic. Notably, the number of participants choosing a 9 or 10 for their confidence dropped from 19 in the first activity to just 8 in the pandemic confidence activity. These charts are available in the appendix entitled "Overall Role Confidence" and "Pandemic Role Confidence."

Though none would claim the pandemic has been a positive experience, some PRCs report **successes** that may **continue to impact their work** beyond COVID. Namely, the shift to technologically-based or distance services has opened doors for some that were not providing these services previously. Some PRCs report that they and/or their sites learned that integrating phone- and web-based support is possible, and that they may **continue to provide these services** as a supplement to future in-person services. Some note that the use of technology during the pandemic has even **increased their reach**, allowing them to offer services to a broader recoveree base and/or connect more regularly with recoverees.

Other PRCs were laid off or experienced reduced work hours as a result of the pandemic. This caused financial hardship for some, and reactions to said hardship included: 1. Finding other work after their layoff (mostly remaining in the recovery field), 2. Returning to their original organization, but are now seeking employment elsewhere, or 3. Returning to their original organization, but are now questioning the overall stability of the field.

> *"The pandemic changed a lot. It increased stress and anxiety for most. We saw an increase in addiction and mental health issues at the local, state and national level. It changed how we lived, worked and delivered services. We pivoted to a more virtual model. It has been challenging but also has broken down barriers so it's not all bad." – (Female, white, OLBB, mainly supports criminal justice segment)*

> *"Before COVID, I would get 5 to 6 referrals in the hospital [per day]. Now, I get 20 or more a day. The hospital hired two more counselors to help me and [they are] wanting to hire one more. Suicides, alcohol, drugs and domestic violence has jumped since COVID. Everyone seems to be stressed out. I had to make calls, and not connect in person. Now, we are back to seeing people face to face, [but] the numbers are still up." – (Male, Hispanic, OLBB, mainly supports young adult segment)*

> *"I was actually laid off from a job at the beginning of the pandemic and had to end up seeking other employment." – (Male, white, OLBB, N/A)*

Peer Recovery Coach Needs for Supporting Others

For the most part, PRCs feel as if they, **personally, have enough tools and resources to get** through the pandemic (such as access to technology, personal support for their own recovery, etc.). When it came to supporting their recoverees, most were able to transition to offering distance-based support through Zoom sessions and phone check-ins. Many also continue to see recoverees in person, but with the implementation of safety guidelines recommended or mandated by their organizations; for example, one PRC noted they used to be able to transport multiple recoverees at once and have transitioned to transporting one at a time. Another PRC stated that they'll use their discretion when meeting in person, spacing out meetings more and prioritizing meetings with those that are higher-risk or do not have the technology to meet remotely.

Though most of these PRCs feel comfortable using technology to support recoverees at a distance, some mention that **access to functioning devices** and **technology training for themselves and other members at their organization** would be valuable, especially because they note they can see themselves continuing to use increased amounts of technology for support beyond the pandemic.

Still, other PRCs **have not found good "workarounds"** through the pandemic and are eagerly awaiting the "all clear" to return to providing support in the manner they did pre-COVID. Though these PRCs have not found adequate workarounds, they have **difficulty identifying a solution** that could help beyond returning to their normal work. These PRCs tend to support many recoverees that do not have access to technology or the skillset to use technology, and so anything short of resuming in-person, full capacity work feels inconsequential.

> *"I guess having a laptop that works [would have helped]. I've had to switch from PC to MAC and THAT HAS BEEN A HUGE PROBLEM FOR ME! I feel so inadequate." (Female, white, OLBB, mainly supports young adult segment)*

Needs of Recoverees

More significantly, PRCs discuss the needs of their recoverees throughout the pandemic. **Technology continues to be a major barrier for recoverees during this time**, with many having little to no access to devices, Wi-Fi, and usage-training. This is particularly true among the homeless population and those involved in the criminal justice system. Some sites were able to provide prepaid phones to their recoverees. Others were able to offer spaces for recoverees to come in and utilize devices and Wi-Fi, though COVID restrictions greatly reduced capacity in many of these instances. **PRCs express that more access to devices, free and reliable Wi-Fi, and training for use of technology is needed** as long as the pandemic continues.

Many community resources are closed, with some just beginning to open back up. As a result, PRCs note that there are **not nearly as many opportunities to recommend support** for their recoverees. This is especially true among PRCs with early-stage recoverees, when many believe meetings and social support to be essential. Until COVID restrictions are lifted entirely, PRCs continue to seek open, functioning, community resources for their recoverees.

> *"I have gotten into the swing of things in the new digital world but, sadly, I know that a lot of folks are not benefitting from my services due to inability to access reliable internet and financial resources to obtain devices to engage with a peer. Especially our unhoused population and the folks in jail or prison." (Female, white, OLBB, N/A)*

Self-care & Burnout

All things considered, PRCs are passionate about the work they do. For many, the work can be described as "a labor of love." PRCs report that, in addition to the desire to give back to the community, **the role also gives back to them**. For many, there is an inherent element of reward and satisfaction embedded in the work they do, which many identify as a form of self-care in and of itself. However, most still identify that it is important to have other methods of self-care beyond the workplace to prevent burnout or compassion fatigue. Notably, almost all PRCs in this study reported **experiencing burnout or compassion fatigue** at some point in their careers; some are actively experiencing this. PRCs at greatest risk for burnout are those who: feel unsupported in their work environment; have large caseloads; and/or have experienced significant changes to their role as a result of COVID (namely reduced hours and limitations in the ways they can provide support).

Self-care activities primarily take the form of recreational activities, or activities to maintain their own recovery, with PRCs noting that this is incredibly important, to ensure they don't exhaust themselves supporting others and risk relapse themselves.

Recreational self-care activities mentioned include:

- Listening to / playing music
- Outdoor activities, such as hiking and fishing
- Painting, drawing, etc.
- Exercising / going to the gym
- Socializing with friends, partner, etc.
- Cooking
- Getting proper sleep

Recovery-focused self-care activities include:

- Attending meetings and peer support groups
- Meditation, prayer, and mindfulness
- Meetings with sponsors
- Therapy

Though PRCs feel as if they have a good understanding of how to participate in self-care, they also note that time to practice it is a major barrier. Even among those who feel they are adequately practicing self-care, they comment on how important it is to "make the time" to do so, even when challenging. There are **opportunities for workplaces** to be more supportive of PRCs by **creating a culture that emphasizes self-care,** allowing PRCs to ask for and receive support when they are nearing burnout.

> "*I currently am practicing yoga, attending support groups including 12-step and Harm Reduction Works. I also practice a variety of meditation practices each day. I would include the Sauna in this as well, it is probably the activity that I most look forward to. These methods are helpful, but a lot of the time I stretch myself so thin and mismanage my time/procrastinate that at times I feel overwhelmed by the seemingly insurmountable tasks that I have deadlines on. What prevents me from this is work-related stress and a desire to disassociate from reality. I also get down and out when I do not take care of my own priorities in regard to recovery. Also, being criticized at work for poor performance resulting from lack of self-care instead of providing opportunities to take more time off and breaks while assuring that my clients will be taken care of while I am out. A lot of times I feel guilty when I take time off because the thought of my people not having me as a resource stresses me out.*" *(Male, white, OLBB, mainly supports criminal justice segment)*

> *"[I'm leaving my current job because] the 24-hour line and all the other stuff that comes with it…basically, [I needed my employer] to allow me more self-care. My hours now are 9:00 to 6:00 whereas [at my new company], they'll be 8:00 to 4:00. And so, I'm able to be home for my daughter [now] (Female, white, IDI, mainly supports professionals / those in the medical field).*

RECOMMENDATION FOR FUTURE QUALITATIVE RESEARCH / QUANTITATIVE FOLLOW UP

The qualitative phase of research provided insights into the experiences of Peer Recovery Coaches. FORE is planning to conduct a follow-up survey among PRCs in specific states and, ideally, across the US to build on this research and help further understand the Peer Recovery Coach experience. In particular, the survey can quantify or measure:

- The incidence and magnitude of experiences among PRCs (and potentially how they may vary by specific demographics) such as:
    - Certification awareness, hurdles, satisfaction, and opportunities
    - Workforce experiences, including stigma, difficulty securing employment, and team inclusion
- Suspected variances in needs among PRCs that support different populations, specifically those who support:
    - Hispanic Spanish-speakers
    - Homeless recoverees
    - Pregnant / parenting women
    - Rurally-based recoverees
- The long-term difficulties surrounding the impact of the COVID-19 pandemic, including:
    - Technological limitations and barriers
    - Relapse and reuse effects and support opportunities
- PRC interest in specific opportunities for support mentioned throughout the qualitative research, including:
    - Increased education for other professionals / the general public to spread awareness and improve understanding surrounding the PRC role
    - Creating company cultures that support self-care to prevent burnout
- The nature and magnitude of the career trajectory and fiscal limitation concerns that arose in this study
- Incidence and magnitude of varying recovery paths (namely, all-recovery vs. abstinence) and the ways in which this variance impacts:
    - Professional perceptions of peer recovery coaches (especially among peer recovery coaches participating in MAT, themselves)
    - How peer recovery coaches support recoverees on recovery paths different from their own

This research also uncovered the potential limitations that exist for Hispanic / Spanish-speaking PRCs when supporting Hispanic / Spanish-speaking recoverees. To better understand these challenges, an additional round of qualitative research (in the form of in-depth interviews) is planned. The additional research will build upon this new learning by adjusting recruitment criteria to ensure Hispanic / Spanish-speaking peer recovery coaches, specifically, are invited to participate in these interviews (whereas the previous recruitment criteria aimed for an even mix of ethnicities, including Hispanics).[4]

[4] For these additional interviews, the screener has been adjusted to identify those that self-report as: Hispanic; supporting the Hispanic population; and specifically support the Hispanic population in Spanish and English (ideally).

PHASE 3 – HISPANIC INTERVIEWS ADDENDUM

Background

Among the four Hispanic PRCs that participated in Phases 1 and 2, only one felt able to speak to the unique needs of Hispanic recoverees. The one bilingual PRC (interviewed in Phase 2) indicated that Hispanic PRCs are currently underrepresented in the country, corroborating the difficulty in recruiting participants that met this requirement. As such, an additional phase (Phase 3) of in-depth interviews (IDIs) were scheduled to explore potential differences, barriers, and opportunities that are unique to the Hispanic PRC / recoveree population.

Key Objectives

In this third phase of research, the objectives were to:

- Explore potential barriers to becoming / remaining a PRC for the Hispanic population, in particular.
- Gain a better understanding of how the relative lack of Hispanic PRCs may have an impact on the recovering community – namely, what, if any, are the unique needs of this population?
- Identify if and how the experiences of Hispanic PRCs vary across key categories explored in the first two waves of research, including the certification journey, workforce experiences, and COVID-19 implications.

About the Participants / Criteria for Recruitment

Three additional IDIs were conducted in Phase 3 to supplement the first wave of IDIs and expand upon findings. Primary criteria for recruitment aimed to identify those that:

- Self-identify as Hispanic
- Support the Hispanic population (all three participants report that at least 25% of those they support are Hispanic)
- Ideally support the Hispanic population in both English and Spanish (all three participants met this criteria)

Though recruitment also aimed for a mix of age, work setting, gender, etc., once again, recruiting Hispanic participants proved to be difficult. Of these three participants, all:

- Are male
- Are certified in the state of New York
- Are located in a major metropolitan area

Participants report a mix of:

- Area(s) of expertise
- Work settings

Participants were also required to have some form of certification qualifying them to identify as a "peer recovery coach." A detailed participant profile can be found at the end of this report.

Analytical Notes

Findings from Phase 3 are based on a sample size of three (N=3). These findings are not generalizable and are, instead, meant to add supplemental insights and richness to our existing phases of qualitative research. Readers of this research are advised to consume the proceeding information with this understanding.

Additionally, as all participants in this phase were certified in the state of New York, a different title preference emerged. Participants report that, in the state of New York, the title CRPA (which stands for certified recovery peer advocate and is pronounced "*sir-pa*") is preferred among those that have the certification. For consistency and inclusion, this addendum will still refer to participants as PRCs, throughout.

Phase 3 Findings

Drivers to Become a Peer Recovery Coach

In addition to the primary drivers uncovered in the first two phases of research, a potential secondary motivator to become a peer recovery coach emerged in Phase 3. **Hispanic PRCs share that they recommend that those in recovery consider becoming PRCs, themselves.** More than in the previous phases, Hispanic PRCs in this third wave of research shared more readily that they are recommending this to their recoverees. One possible explanation for this being mentioned specifically by Hispanic PRCs may be their awareness that there is **a lack of Hispanic representation in the field**. Hispanic PRCs did not specifically identify this as a reason they recommend their recoverees become PRCs, however, they did point to the benefit of sharing lived experiences with their recoverees and also noted that as a bilingual PRC, their services are in demand.

> *"As a peer advocate when I speak with the peers…there's a lot of times that I have to share my personal recovery story so they can understand that, listen, I know what it is to be homeless. I know what it is to be in and out of jail. But look at me today where I'm at. I turned my life around and the sky was the limit. Even though I got sick [in recovery], I still chose to come to [this town] and do what I got to do. So, it motivates them. They'll be like, 'Wow, that's awesome.' A lot of them, I send them… [to a recovery center and] they do the trainings there for the recovery coach [certification]." – (Male, Hispanic, IDI, mainly supports criminal justice segment)*

> *"So, meeting the peers, as a CRPA we're change agents. So, our job is to change them for the better, give them the information and resources. We share our personal recovery stories in the hopes of motivating them and encouraging them to see that there is hope after dope." – (Male, Hispanic, IDI, mainly supports criminal justice segment)*

The Certification Journey

Hispanic peer recovery coaches experienced some unique language-specific challenges in their certification journeys. Hispanic PRCs share that classes are primarily taught in English, which can present challenges for ESL PRC candidates and monolingual Spanish-speaking PRC candidates. While PRCs notice that the number of Spanish-speaking instructors seems to be increasing, they also note that **study materials and certification exams are entirely in English**, creating a significant barrier for those that are Spanish-speaking and wish to become certified. Furthermore, **this barrier creates a cyclical effect** wherein more Hispanic / Spanish-speaking PRCs are desired within the field, but the language barrier causes complications in the certification process, causing Hispanic / Spanish-speaking PRC candidates to withdrawal from the certification journey, continuing the cycle.

> *"The trainings are all done in English, so we do have a large population of monolingual peers that would make excellent peer advocates or recovery coach; however, due to the fact that they are not [English speaking, there is a barrier]." – (Male, Hispanic, IDI, mainly supports criminal justice segment*

> *"The recoveree coaching training, now they're starting to do it in Spanish. But it was never like that. So, the individuals who were Spanish-speaking only and wanted to be a recoveree coach, they couldn't really pursue that because it was all in English. So now I call the OASAS, they finally woke up and they said, 'Oh my God, we need recoveree coach training. We need peer services that are driven by who, [Spanish] speaking people who can reach their community,' and that's happening slowly. And I think that that's wonderful." - (Male, Hispanic, IDI, mainly supports homeless segment)*

All three PRCs in this phase **were certified in the state of New York** and do not feel that the process is nearly as complicated as PRCs in other states reported. When asked to discuss the process, the PRCs in this phase discuss that the CRPA certification is a recognized and distinctive credential to hold in the field; CRPAs are Medicaid billable, allowing them to serve those on public assistance. They were **clearer than others on the sequential steps, program requirements, and funding options available to them** and cite the Office of Addiction Services and Supports (OASAS) as a key source of information through their journey (https://oasas.ny.gov/recovery/become-certified-recovery-peer-advocate). Due to the distinction in credentialing, there also tends to be more clarity surrounding titles and those in this phase of research preferred to be identified as a CRPA (though it is worth reiterating that most PRCs, including those in this phase of research, caution against title usage with their recoverees to refrain from creating an implied hierarchy between themselves and those they support).

> *"And so they said, we're going to open up the doors and we're going to incorporate a different field. So, what OASAS did was, they changed their acronym. Now it's called the Office of [Addiction] Services and Support. The key word is support…and all they're based on is what I'm talking about." – (Male, Hispanic, IDI, mainly supports homeless segment)*

Overarchingly, PRCs in this phase found the course curriculum to be all-encompassing and helpful. While none identified opportunities to improve the curriculum or experience organically, they did respond to the idea of **incorporating technological training into the curriculum** when prompted. While this may be enhanced by the effects of COVID-19, PRCs agreed with earlier findings surrounding the desire for more comprehensive technology training for PRCs, including hardware usage for offering support virtually and software training such as Microsoft Office Suite.

"At the very least. Teach them how to use Word. Teach them how to use Outlook." – (Male, Hispanic, IDI, mainly supports older males)

Workforce Experiences

Hispanic PRCs reported more positive workforce experiences than some of the PRCs in previous phases (where we saw high variety among PRCs when it came to their feelings of integration, respect, and appropriate assignment of responsibilities in the workforce). Hispanic PRCs in this research phase generally felt appreciated and well-respected within their organizations, some **feeling like specialists** in their place of work. One potential reason for this is that Hispanic Spanish-speaking PRCs report feeling **valued for their bilingual skillset**.

"I'm very fluent in Spanish. I speak it very well…So I'm an asset, because I'm also bilingual. So, I help out that community, the monolingual individuals, [in] a situation where I can communicate and get the information across." – (Male, Hispanic, IDI, mainly supports homeless segment)

Cultural Considerations for Recoverees

As indicated in the first two phases of research, there is an overarching theme of "sameness" when it comes to a PRC's approach in supporting members of the recoveree community. While this phase of research teases out nuances specific to the Hispanic population, the general consensus remains that **PRCs do not approach supporting individuals through any particular lens related to population characteristics**. Instead, they approach support based on each person's individual needs and pride themselves on their ability to "**meet recoverees where they're at**." This is often extrinsic from ethnic, cultural, socioeconomic, or any other population-specific needs, and more often has to do with where they are (which stage of change they're at) in their recovery (and one PRC noted that **drug of choice** may be an important consideration). However, while cultural considerations are not the primary lens through which the recoveree's journey is conceptualized, some experiences are consistent enough for Hispanic PRCs to feel that they are unique to the Hispanic population.

"That's the one thing about addiction. Addiction doesn't really have a racist bone in it. It has bias, and you'd be surprised. The bias has nothing to do with color. It has to do with drug choice." - (Male, Hispanic, IDI, mainly supports older males)

While the need for social / community support emerged in previous research phases as an important factor in recovery, Hispanic PRCs note that the Hispanic culture is highly communal. As such, social / community support is perceived as even more important in the recovery for Hispanics. Unfortunately, the PRCs in this research feel as if **the Hispanic population is less likely to seek and/or receive social and community support** for several reasons elaborated on below, including (1) lack of culturally appropriate resources; (2) lack of resource awareness and (3) fewer options after recovery

Lack of Culturally Appropriate Resources:

As we know from the first phases of research, PRCs consider their roles as "resource brokers" to be a significant part of their job responsibilities. This is to say, referring recoverees to social services that can offer assistance in both OUD recovery, as well as aide in obtaining basic needs, is viewed as a primary

function of the job. Community resources such as housing, financial aid, career and skill development, etc. are said to be offered **primarily in English**, presenting a hurdle for those that are primarily Spanish-speaking or exclusively Spanish-speaking. In these cases, PRCs acknowledge that there is significant need for more community resources in Spanish.

> *"There's a lack of bilingual [services] or bilingual clinicians. That's the key. Because you can go into a community-based organization and they have all these services that are available, but if there's no one to present the services in their language, it's futile." - (Male, Hispanic, IDI, mainly supports homeless segment)*

Lack of Resource Awareness:

Additionally, Hispanic PRCs reported that Hispanic recoverees may simply be unaware of resources that are available to them. Though none would state there is an abundance of Spanish-specific resources available to Hispanic / Spanish-speaking recoverees, one PRC did report that there are resources available, but that there is limited awareness of these resources. This PRC noted that he found success in door-to-door initiatives wherein he informed Hispanic community members of available resources and offered to enroll them in a recovery program.[5] One PRC observed that **Hispanic individuals are more likely to be on MAT (medication assisted treatment) plans**, once they are aware of the fact that this is an option. According to PRCs, for many Hispanic people in recovery, awareness of treatment options still feels limited to abstinence-based recovery (such as 12-step programs). This is an interesting point of differentiation, as one Hispanic PRC noted that there is an additional layer to opioid use for Hispanics – this PRC reported that, in his experience, Hispanic recoverees are particularly avoidant of withdrawal symptoms. This may imply that **recovery may be more appealing to Hispanic individuals** once they are aware of and educated on MAT options, since, currently, emphasis for the population seems to be on abstinence-based recovery (wherein withdrawal symptoms are an inevitability for many).

> *"I'm going to be blunt with you about the Hispanic and African American population that we deal with. The services are there. Either they don't know how to reach them, or they don't want to do it."- (Male, Hispanic, IDI, mainly supports older males)*

> *"With the Latino population that I serve, they gravitate more to MAT, Medication Assisted Therapy…I think because historically, there weren't a lot of services for Latinos period. So, Latinos depended on each other. Remember, addicts have their own culture. They have their own system. They have their own beliefs. So, an addict is not going to leave another addict sick. Do you know what I mean? Another addict is going to help another addict to use. So, that community is very closed in and they have a tremendous bond. And most Latinos who suffer from opioid addiction fear the effects of being sick, the illness aspect… whereas Methadone, Suboxone, this type of medication, what it does, it gives them an opportunity." – (Male, Hispanic, IDI, mainly supports homeless segment)*

[5] This PRC also found door-to-door initiatives to be effective for Black community members.

Fewer Options After Recovery:

Hispanic PRCs indicate that there may be fewer options available for Hispanic recoverees after recovery. As we learned in the first two phases of research, PRCs often find sense of purpose and fulfillment in entering the peer recovery / peer advocate space. For some, it appears that becoming a PRC or giving back to the recoveree community in a similar way can be a step in one's own recovery, and it is apparent that **a link may exist between this learning and the fact that Hispanic recoverees face additional hurdles to become PRCs**. Due to the language-related challenges (primarily discussed in "The Certification Journey" section of this addendum), **these options can be limited for Hispanic (specifically monolingual Spanish-speaking) recoverees**.

As an additional cultural consideration for Hispanic recoverees, Hispanic PRCs noted that a significant portion of those they support are court-mandated. It is suspected that some of these individuals **may be in a different stage of change** than a voluntary recoveree. Additionally, Hispanic PRCs express that a portion of both voluntary and court mandated recoverees may have ulterior motives for seeking treatment, such as preemptively enrolling in a program for an upcoming court case. Nevertheless, Hispanic PRCs note that this is still an **opportunity to meet the recoveree where they're at** and encourage change, regardless of motive.

> *"15% come on their own…90% of those 15% have a hidden agenda. They got a child neglect or child abuse case, they have an ACS case, and they're coming to beat the system. They're coming ahead of time so that when they go to court they say, 'Oh, I'm in a program'…What I do is I tell them, 'Listen, you did a smart move. It's awesome, great. We're going to help you with this.' – (Male, Hispanic, IDI, mainly supports criminal justice segment)*

COVID-19 Implications

As mentioned, Hispanic PRCs report a strong sense of community among the Hispanic population. Hispanic PRCs reported that community resources (which already feel limited for Hispanic / Spanish-speaking recoverees) became even more limited throughout the pandemic as a result of safety guidelines. As such, PRCs noted that Hispanics recoverees struggled disproportionately during this time, and as a result, **relapse and reuse rates were higher among the population.** Specifically, a decline in mental health directly related to the pandemic was noticed, **causing an uptick in comorbidities.**

> *"Especially now because of COVID, [we're seeing] what we consider co-occurring, comorbidities, like co-occurring disorders. Because not only are they dealing with their, opioid addictions, [but] also dealing with mental health: depression and anxiety disorders. Many have to combat that on top of the list of substance use." – (Male, Hispanic, IDI, mainly supports homeless segment)*

Opportunities to Support

In moving forward, Hispanic PRCs discussed the need for:

- **Certification resources in Spanish:** This includes instructors, study materials, and the test itself
- **More Hispanic community resources:** More resources that are culturally competent and in Spanish that include safe-use spaces, All Recovery Meetings, MAT education, and basic-needs resources (such as those that focus on housing, financial support, etc.)
- **Grassroots initiatives from both PRCs and policy makers**: Door-to-door PRC education efforts, and one Hispanic PRC noted that policymakers spend time on data collection and analysis, but rarely enter the community themselves to engage with the Hispanic population; as such, policy and funding opportunities for OUD resources feel informed by data vs. true population-specific needs

  "I see that what's more needed within this community is a safe haven, a place where they can go and you feel a sense of normalcy. Or something like a clubhouse type setting where they can go, for example, person goes and uses and wants to go somewhere where they can just sit down and relax. And go into a tranquil state of mind and not feel pressured. Having a safe haven, like injectable safe sites, for example, where they can do the illicit substances in a nonjudgmental way. And afterwards given that opportunity to share how they feel, if there's anything I can do to assist them moving forward. And that happens to be something that's very lacking, especially with the Latino community." – (Male, Hispanic, IDI, mainly supports homeless segment)

  "That people like HMO and government funding, their heart is in the right place, but for them to stop focusing on data and look at the human people, the humankind. These politicians, they speak a good game, but go to the communities, see for your own eyes." – (Male, Hispanic, IDI, mainly supports homeless segment)

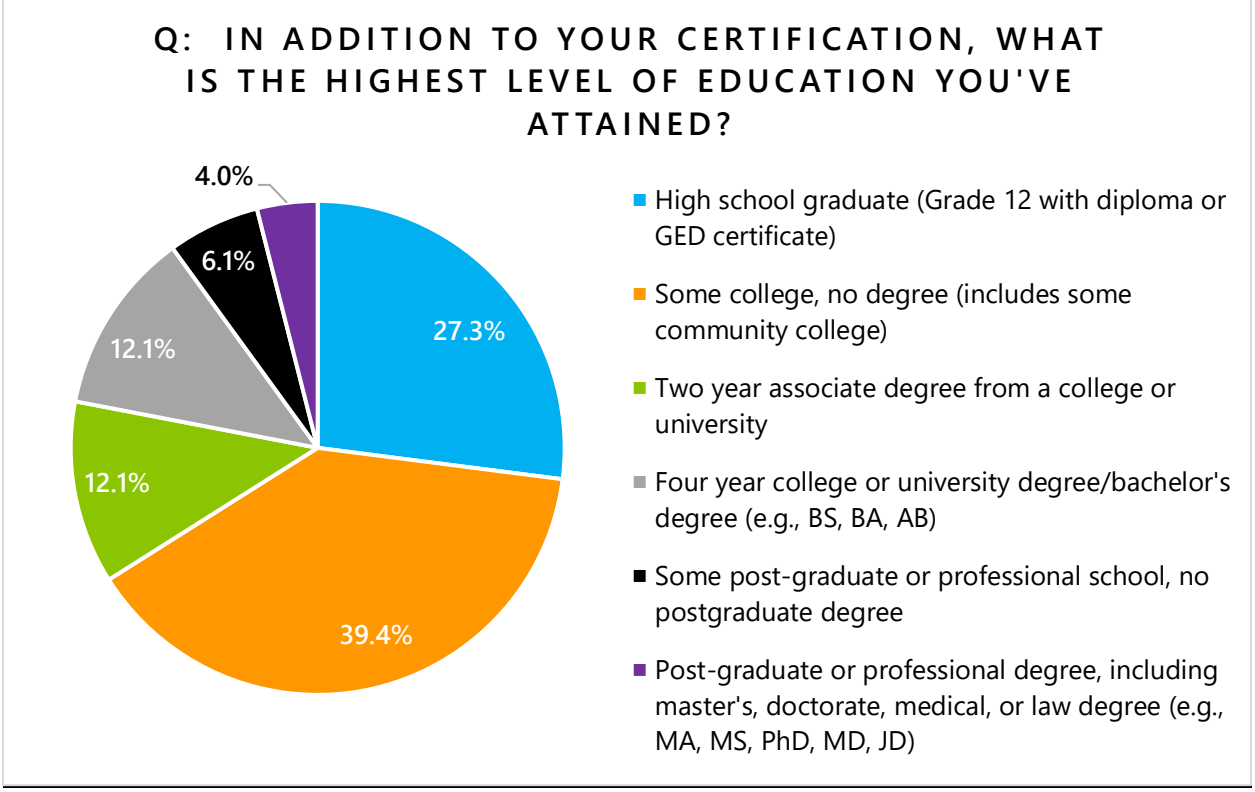
APPENDIX

Participant Exercises[6]

During the online bulletin board portion of the research, participants were asked to complete several activities to encourage deeper thought and illustration of the PRC experience. The exercises were as follows:

Level of Education

PRCs (n=33[7]) were asked to select their highest level of education, in addition to certification, from a pre-populated, single-select list. Respondents were then asked to report how useful their education is to them, and how interested they are in perusing additional education. Responses varied widely, with some reporting their education is very useful and others reporting their education is not useful. Some report they are very interested in pursuing additional education, and others report they have no interest. Responses do not appear to reflect any preferences based on segmentation.



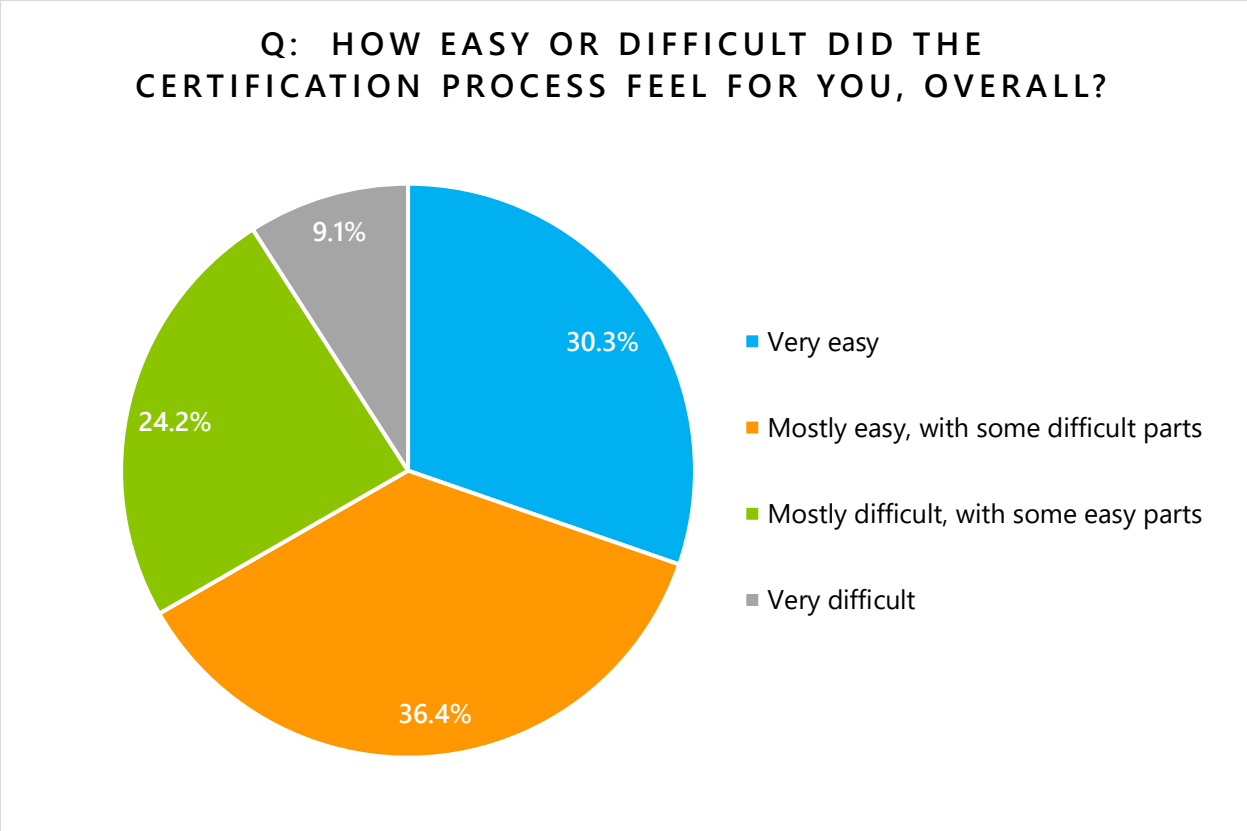
[6] As mentioned in the Analytical Notes section of this report, it is important to note that this research is qualitative in nature and should be used directionally. The nature of the data collection and the sample sizes do not allow for extrapolation of results to a larger population. The data are not necessarily representative of *all* peer recovery coaches.
[7] N=2 Participants who did not complete the full OLBB responded to this question.

Ease of Certification Journey

PRCs (n=33[8]) were asked to reflect on the process of obtaining their certification, and select (from a single-select, prepopulated list) how easy or difficult the certification journey was. Options were:

- Very easy
- Mostly easy, with a few difficult parts
- Mostly difficult, with a few easy parts
- Very difficult

Respondents were asked to explain their selections. Results are outlined in The Certification Journey section of this report.

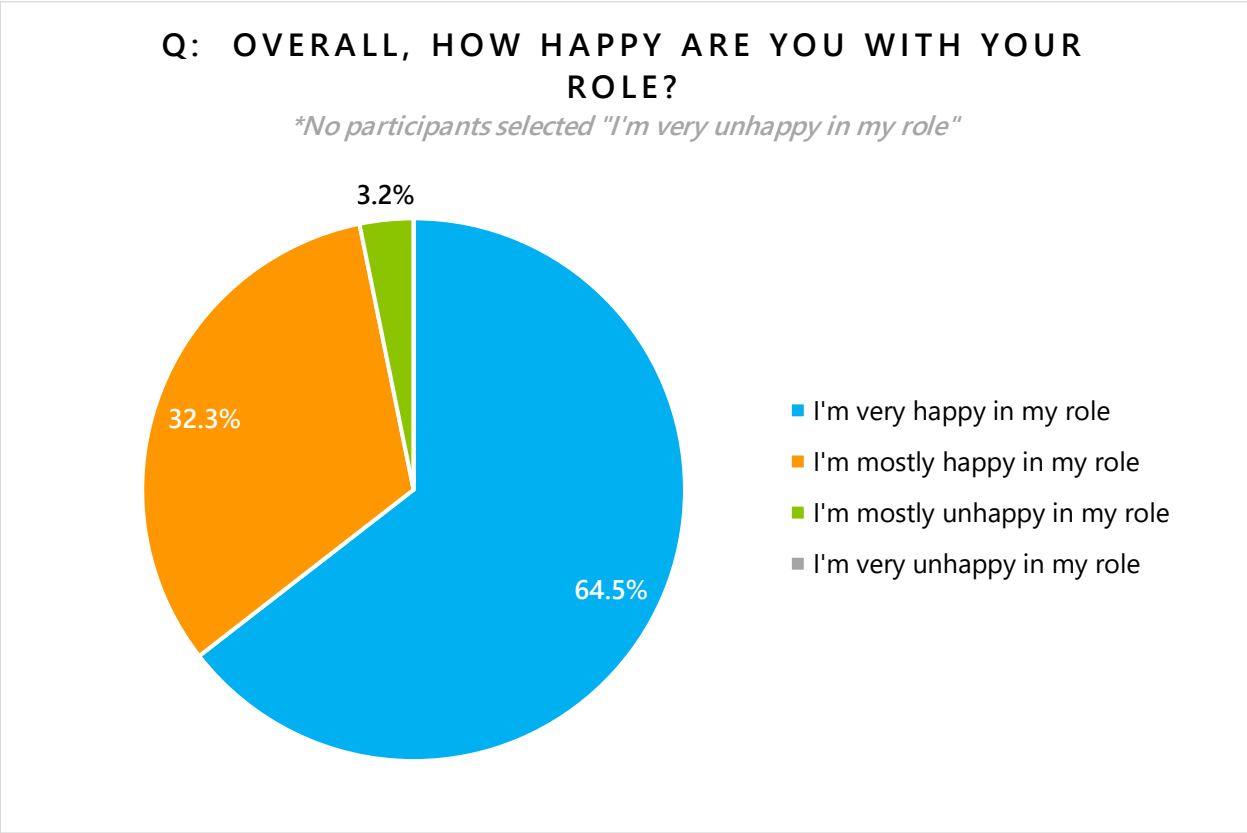


[8] N=2 Participants who did not complete the full OLBB responded to this question.

Job Satisfaction

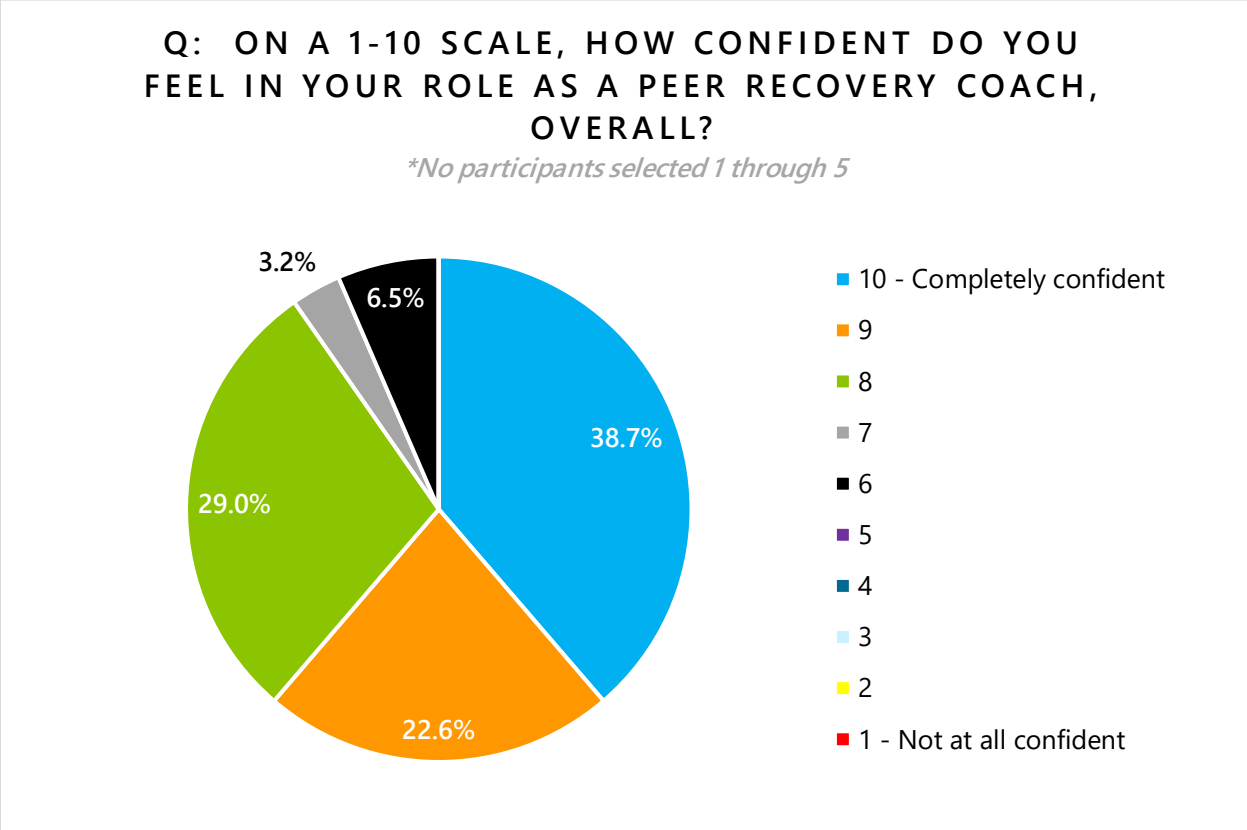
PRCs (n=31) were asked to identify how happy they are in their role, overall. Options included:

- I am very happy in my role
- I am mostly happy in my role
- I am mostly unhappy in my role
- I am very unhappy in my role (no respondents selected this answer)



Overall Role Confidence

PRCs (n=31) were asked to rate their overall confidence in their roles as Peer Recovery Coaches on a 1-10 scale, with 1 being the least confident and 10 being the most.



Expectations vs. Reality

PRCs were asked to write a letter to their younger selves, discussing all the things they know about the role now that they wish they knew, then. Respondents were encouraged to include anything they'd give their younger selves a "heads up" about and share any advice they have. Some themes that emerged included the sense of purpose that comes with the role, the hardships of losing recoverees, and the importance of self-care. Some letter excerpts include:

> *"Hey man, this job is the best job you'll ever have. It's hard. People are going to change. People are going to die, but it doesn't change your work. This is YOUR work. You were given talents and you know this. Watch your feelings, self-care is super important. Your family will support you but be careful." (Male, white, mainly supports homeless segment)*

> *"I know you're pursuing your certification because you think it is the best way to be part of the boys' lives, their recovery, but this has nothing to do with them. Being a recovery coach is going to be all about YOU. You're going to find that you need to work on yourself - be strong and confident in your beliefs as well as your personal ethics. You won't be able to help everyone. People are going to die and you are going to find out that there is so much pain in the world. However, the work you're going to do will help many people." (Female, white, mainly supports criminal justice segment)*

Role Challenges

PRCs were asked to write a letter to their friend venting about the challenges and frustrations in the role. They were also asked to identify any ways they imagine these things could be made easier. Some themes that emerged included stigma, lack of resources, and the need for general public / professional education regarding substance use disorder. Some letter excerpts include:

> *"Dear Friend, I am entirely frustrated with the barriers of the healthcare system and availability of funding for SUD education. Ten years ago, I was frustrated by the stigma and the shame that kept family members from asking for help. Today, I am frustrated by all of the voices asking for help that do not receive it." (Female, white, mainly supports criminal justice segment)*

> *"Resources for housing, transportation, childcare, employment, etc. are few and far between and is a huge barrier for people in early recovery - especially when they first get out of jail or treatment. Education is something that needs to be improved especially within the healthcare space so professionals have more knowledge and understanding about substance use disorders and can hopefully gain more empathy and compassion. Also, more funding needs to go to helping folks who are in early recovery with the basic necessities of life - a roof over their head, food on the table, and a job." (Male, white, mainly supports criminal justice segment)*

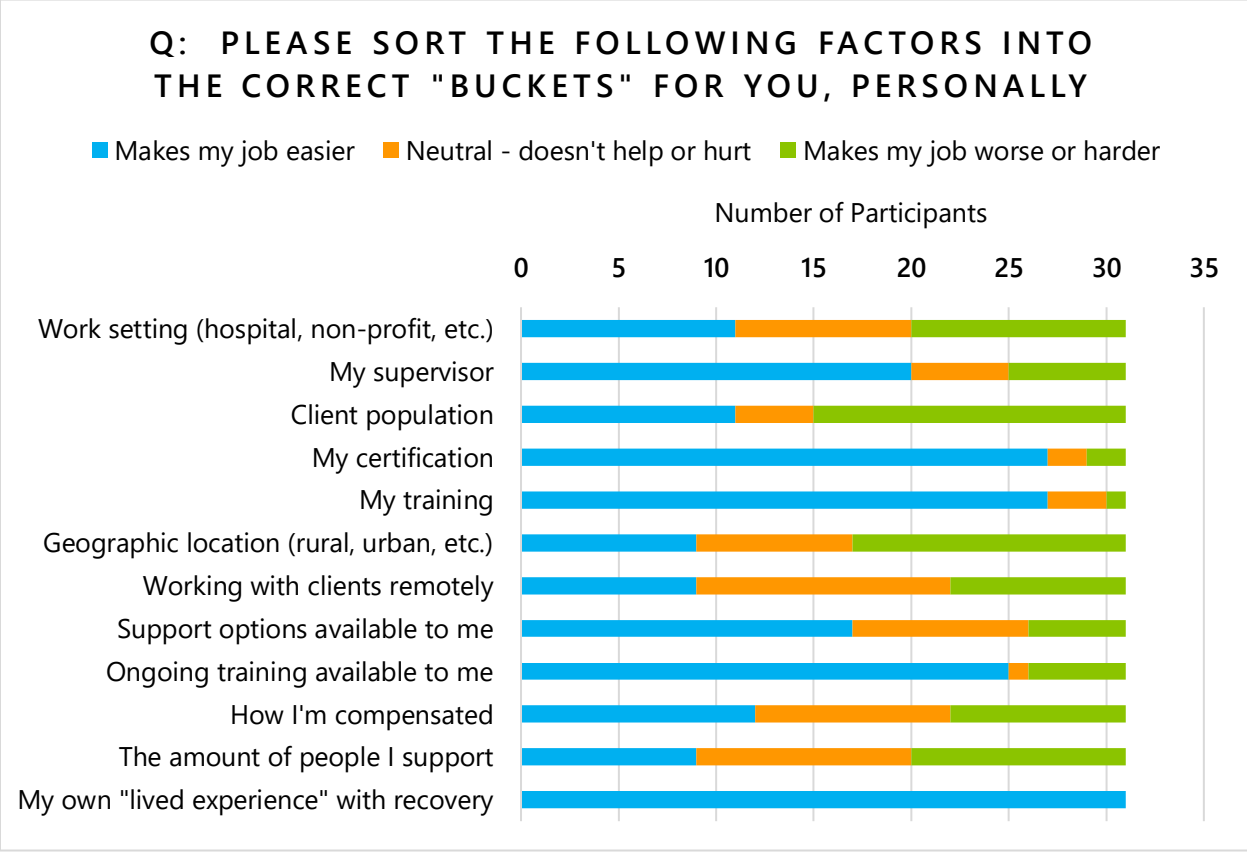
Aided Role Challenges

PRCs were asked to complete a sorting activity entitled "Aided Role Challenges." In this activity, respondents saw a list of factors related to their work, as well as three "buckets" the factors could be sorted into. The factors included:

- Work setting (hospital, nonprofit, etc.)
- My supervisor
- Client population
- My certification
- My training
- Geographic location (urban, rural, etc.)
- Working with clients remotely
- Support options available to me
- Ongoing training options available to me
- How I'm compensated
- The amount of people I support
- My own 'lived experience' with recovery

Buckets for sorting included:

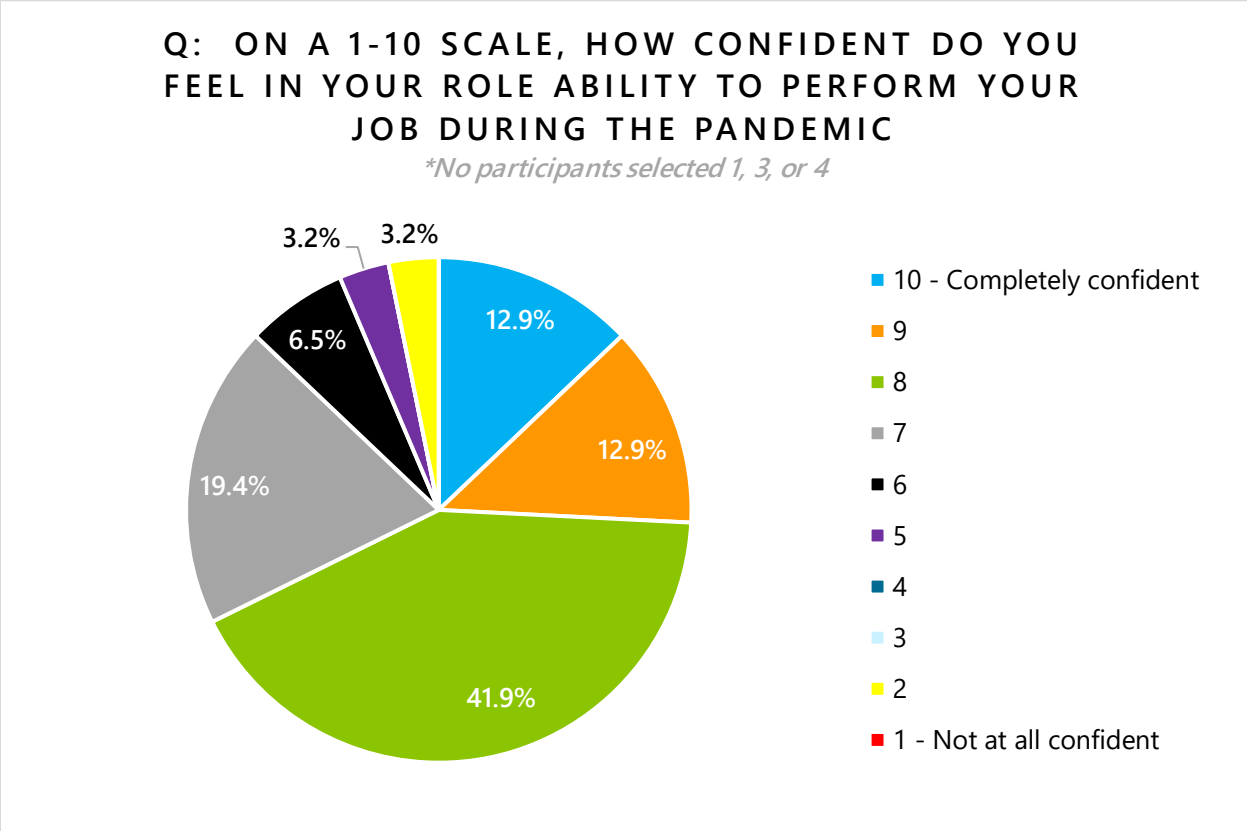
- Makes my job better or easier
- Neutral – doesn't help or hurt
- Makes my job worse or harder



Notably, all participants (N=31) assigned "my own lived experience with recovery" to the bucket "Makes my job better or easier." The report above reflects this information in the sections "Population-Specific Needs" and "Integration of Personal Recovery."

Pandemic Role Confidence

After discussing the impact of the COVID-19 pandemic, PRCs (n=31) were asked to rate their confidence in their ability to perform their jobs as Peer Recovery Coaches on a 1 to 10 scale, with 1 being the least confident and 10 being the most confident. Differences between the "Overall Role Confidence" activity and this one are discussed in the "Covid-19 Implications" section of this report.



Participant Demographics[9]

	Phase 1 OLBB	Phase 2 IDIs	Phase 3 Hispanic IDIs	Total
Gender				
Male	16	7	3	24
Female	15	10	--	23
Age				
Under 35	11	2	--	11
35-44	10	5	--	14
45-54	3	6	--	8
55+	7	4	3	14
Ethnicity				
White	26	6	--	29
Black	3	8	--	11
Hispanic	2	3	3	7
Geographic Location				
Urban	12	6	3	20
Intermediate	11	9	--	18
Rural	7	2	--	8
Unspecified	1	--	--	1
Work Setting				
Emergency Departments	3	--	--	3
Primary Care Offices	3	1	--	4
RCOs	20	12	1	29
Other	5	4	2	11

[9] As mentioned earlier in the report, n=4 participants from Phase 1 were also interviewed in Phase 2.

	Phase 1 OLBB	Phase 2 IDIs	Phase 3 Hispanic IDIs	Total
Populations Supported[10]				
Veterans	24	10	2	32
Criminal Justice System	28	16	3	43
Young Adults	27	12	2	38
Pregnant/Parenting Women	19	9	3	30
Homeless	28	12	3	39
Other	1	5	--	5
Population Supported Most Often[11]				
Veterans	2	--	--	2
Criminal Justice System	14	10	1	21
Young Adults	7	--	--	7
Pregnant/Parenting Women	1	--	--	1
Homeless	5	6	1	11
Other	3	2	1	6

[10] Q9. Can you please tell us the types of populations you are supporting? [Check all that Apply]
[11] Q9a. [If Q9 has multiple responses ask:] Of the populations mentioned (insert Q9 responses), which would you say you support the most?