Open Aid Alliance (OAA) is one of the few syringe exchange programs and HIV/AIDS service organizations in Montana. Specific agency services include HIV, hepatitis C, and sexually transmitted infection (STI) testing and counseling, syringe exchange services, housing assistance, and healthcare referrals. In 2017, the agency launched Uncovery, a substance use disorder treatment center, and in 2018, with funding from Substance Abuse and Mental Health Services Administration (SAMHSA), the agency launched the Uncovery Peer Support Program.

OAA describes their services as “recovery-oriented, person-centered, voluntary, relationship focused, and trauma informed” (SAMHSA grant application, 2017, p.4). All services are provided within a harm reduction model of care, a low-barrier approach to providing services to clients regardless of substance use. Both the harm reduction model and the peer recovery support services expand the network of recovery options for some of the area’s most vulnerable citizens.

As a requirement of the SAMHSA grant, Open Aid Alliance sought to review program progress via an externally contracted local performance assessment. The overarching goal of the performance assessment is to measure progress in achieving the goals, objectives and outcomes set forth by the SAMHSA BCOR grant proposal.

The performance assessment seeks to measure intended impact, including increasing access to high quality peer support services, and impact on clients as a result of recovery support services. Program successes, barriers encountered, and efforts to address barriers will be highlighted. Data from the assessment will inform program improvements and refinements.

The target groups of the evaluation were:
- OAA staff
- Community Partners
- Participants utilizing Uncovery Peer Support Services.

A qualitative approach was used to gather feedback from OAA staff, community partners and participants utilizing Peer Support Services via semi-structured face-to-face and phone interviews and a focus group. A total of 14 respondents from three target groups contributed feedback to the evaluation.
The following summarizes the findings organized in themes and recommendations.

**THEME 1:** The peer support workers’ lived experience with addiction and recovery inherently builds trust and safety with participants. These relationships form the bedrock in which to administer and receive support services.

**Recommendation 1a:** Clarify the roles and responsibilities of the peer support worker, identify the role overlap and the role differentiation between case management and counseling roles in the agency.

**Recommendation 1b:** Increase the capacity of peer support workers by improving supervision and ongoing training. Implement and/or enhance the following: a) schedule regular check-ins, b) create back-up support, c) provide continuing education and on-the-job training, d) commit to and implement supportive supervision. Additionally, develop a training program specifically focused on developing skills to leverage self-disclosure in a meaningful and value-added way.

**Recommendation 1c:** Support the recovery of peer support workers. Create a policy to support relapse, clarify substance-use-on-the-job policies and encourage continued recovery support for peer support workers.

**FINDING 2:** Peer support workers link participants to resources within and outside the agency that support recovery

**Recommendation 2a:** Further train peer support workers to become systems navigators that can link participants to critical supportive services. Combine lived experience with professional systems navigation skills to help broker essential services.

**Recommendation 2b:** Track both referrals to supportive services and follow-up with recommended supportive services to better track recovery outcomes.

**Recommendation 2c:** Connect peer support worker with key coordinators at collaborating community agencies to build partnership, communication, and service coordination.

**FINDING 3:** OAA’s harm reduction approach is both a facilitator and a barrier to interagency collaboration

**Recommendation 3a:** Develop a community advisory board to help educate the community on the opportunities and limitations with the harm reduction model. Use the community advisory board as a way to clearly communicate the role of the peer support workers and the hours of services, to promote the critical services provided to the community, and to troubleshoot challenges with interagency collaboration.

**FINDING 4:** Insufficient program infrastructure limits program success and stability

**Recommendation 4a:** Co-create program policies and procedures with staff to stay consistent with the peer support model. Revisit bi-annually via a Rapid Cycle Improvement Approach. Revise as needed.

**Recommendation 4b:** Commit to consistent and thorough program data collection to ensure program fidelity, program improvement, compliance with SAMHSA guidelines, and to secure additional funding.

**Recommendation 4c:** Continue to systematically collect participant feedback on program components (i.e., Groups, one-on-one support, referral) and use feedback to improve efforts.
Open Aid Alliance is one of the few syringe exchange programs and HIV/AIDS service organizations in Montana. Specific agency services include HIV, hepatitis C, and sexually transmitted infection (STI) testing and counseling, syringe exchange services, housing assistance, and healthcare referrals.

In 2017, the agency launched Uncovery, a substance use disorder treatment center. Open Aid Alliance (OAA) describes their services as “recovery-oriented, person-centered, voluntary, relationship focused, and trauma informed” (SAMHSA grant application, 2017, p.4). All services are provided within a harm reduction model of care. The Harm Reduction Coalition (n.d.) describes harm reduction as a “spectrum of strategies from safer use, to managed use to abstinence to meet drug users ‘where they’re at,’ addressing conditions of use along with the use itself” (para. 2). Substance use does not preclude individuals from receiving the agency’s supportive services, thus reaching the most vulnerable individuals who are often excluded from services. This philosophy of care is central to the agency’s mission, and its flexibility to serve individuals in various stages of use and recovery is a notable and unique asset for the Missoula community.

In 2018, OAA received funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) via the Comprehensive Addiction and Recovery Act: Building Communities of Recovery (BCOR) to launch a peer support program. The overarching goal of the peer support program is to increase access to substance use disorder (SUD) recovery-oriented services through a peer support and harm reduction model. The program is intended for residents of Health Region 5 with a particular focus on the area’s most underserved population: people who live with HIV, inject drugs, or experience homelessness, as well as pregnant women or those who are reentering the community after incarceration. Included in Appendix D is a Program Logic Model that highlights program goals, activities, outputs, and outcomes.

The target population for this program and for all agency services are some of the region’s most at-risk and vulnerable citizens. The lives of these participants are further complicated by histories of addiction, trauma, and marginalization.

RECONCEPTUALIZING ADDICTION AND RECOVERY

The Institute of Health and prominent addiction researchers have called for a reconceptualization of addictions treatment (Bassuk, et. al, 2016). Based on an improved and more scientific understanding of drug and alcohol addiction, researchers now recognize that addiction resembles other chronic health conditions where relapse is common, there is no specific cure, and remission and symptom management are possible. The scientific shift to recognize drug and alcohol addiction as a chronic versus an acute condition has changed the recommended approach to addictions treatment (Bassuk, et. al, 2016). It is now acknowledged that an array of services and supports with multiple access points throughout the continuum of care are necessary for addressing chronic health conditions. Similarly, the behavioral health approach to addictions treatment has moved to a recovery-oriented approach which values a “multi-system, person-centered continuum of care where a comprehensive menu of coordinated services and supports is tailored to individual’s recovery stage, needs, and chosen pathway” (Bassuk, 2016, p.1).

SAMHSA defines recovery as “a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential” (SAMHSA-definition, 2016, p.3). Based on this understanding of addiction and recovery, there is an identified and urgent need for multiple supportive pathways to recovery. Recovery ranges from complete abstinence of all substances to managed use of substances (Hunt, 2012). Pathways to recovery can include professional counseling, use of medications, family-based support, faith-based approaches, and peer support (SAMHSA-definition, 2103).

SAMHSA identified four dimensions that support a life in recovery:

1. **HEALTH** – learning to overcome, manage or more successfully live with the symptoms and making healthy choices that support one’s physical and emotional well-being;

2. **HOME** – a safe and stable place to live;

3. **PURPOSE** – meaningful daily activities, such as a job, school, volunteer work, or creative endeavors; and increased ability to lead a self-directed life; and meaningful engagement in society; and

4. **COMMUNITY** – Relationships and social networks that provide support, friendship, love and help (SAMHSA-core competencies, 2015, p. 2).
Peer recovery support services (PRSS) are nonprofessional, nonclinical supports provided by individuals who have lived experience with addiction and who have been successful in their recovery attempts. SAMHSA describes peer support as "a system of giving and receiving help based on key principles that include ‘shared responsibility, and mutual agreement of what is helpful’" (SAMHSA-core competencies, 2015, p. 1). Lived and shared experience as an individual in recovery from a mental or substance use disorder and/or as family member with lived experience lies at the core of peer support.

PRSS are provided to individuals regardless of their stage of recovery. The Montana Peer Support Task Force states that services may:
- “Precede formal treatment, strengthening a peer’s motivation for change;
- Accompany treatment, providing a community connection during treatment;
- Follow treatment, supporting relapse prevention; and
- Be delivered apart from treatment to someone who cannot enter the formal treatment system or chooses not to do so” (MT Peer Support Task Force, 2015, p. 24).

The variety of access points to peer recovery support services means that peer support workers truly meet their clients where they are while aligning with the current conceptualizations of addiction and recovery.

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The variety of access points to peer recovery support services means that peer support workers truly meet their clients where they are while aligning with the current conceptualizations of addiction and recovery.

The terms used to describe the role of peer support include: peer specialists, recovery coaches, peer mentors, substance abuse outreach worker in recovery, peer advocates and recovery support specialists. The Montana Peer Support Task Force (2015) differentiates the terms through a leveling system:

- **LEVEL 1: PEER ADVOCATE**
  (10 hours of training and 5 hours of continuing education required each year of service)

- **LEVEL 2: PEER MENTOR**
  (40 hours of training in addition to Peer Advocate Training, completes 20 hours of continuing education every two years of service, and receives clinical supervision one hour for every 40 hours of work)

- **LEVEL 3: PEER RECOVERY COACH**
  (40 hours of training in addition to both the Peer Advocate and Peer Mentor Trainings, at least 2 years in recovery, completes 20 hours of continuing education every two year, and receives clinical supervision from a Licensed Clinical Social Worker (LCSW) or Licensed Clinical Professional Counselor (LCPC) one hour every week)

Peer support is offered one-on-one and in groups, and is implemented in a variety of settings such as recovery housing, mental health-care settings, recovery community centers, medical outpatient clinics, churches, drug courts, jails and prisons, collegiate recovery programs, community and street-based outreach programs, state hospitals, and peer-run drop-in centers. In either paid or volunteer roles, peer support workers leverage their experience with addiction and recovery to build relationships, inspire others towards recovery, assist in goal-setting, educate on addiction and recovery and link clients to supportive services.
In 2015, SAMHSA developed core competencies to guide the emerging field of peer recovery support services and to promote best practices. The following lists the twelve core competency categories for a peer support worker:

**CATEGORY I:** ENGAGES IN COLLABORATIVE AND CARING RELATIONSHIPS

**CATEGORY II:** PROVIDES SUPPORT

**CATEGORY III:** SHARES A LIVED EXPERIENCE

**CATEGORY IV:** PERSONALIZED PEER SUPPORT

**CATEGORY V:** SUPPORTS RECOVERY PLANNING

**CATEGORY VI:** LINKS TO RESOURCES, SERVICES, AND SUPPORTS

**CATEGORY VII:** PROVIDES INFORMATION ABOUT SKILLS RELATED TO HEALTH, WELLNESS AND RECOVERY

**CATEGORY VIII:** HELPS PEERS MANAGE CRISIS

**CATEGORY IX:** VALUES COMMUNICATION

**CATEGORY X:** SUPPORTS COLLABORATION AND TEAMWORK

**CATEGORY XI:** PROMOTES LEADERSHIP AND ADVOCACY

**CATEGORY XII:** PROMOTES GROWTH AND DEVELOPMENT

**PEER SUPPORT WITHIN A HARM REDUCTION MODEL**

As previously described, the Open Aid Alliance provides services based on a harm-reduction model. Harm-reduction is considered both a pathway to recovery and a social justice movement. Vakharia and Little (2017) write: “(t)he premise of harm reduction is that by welcoming people as they are, and by offering help that meets people’s basic needs, we can increase client engagement and lower their reluctance to change” (p.67). Harm Reduction includes a range of strategies from abstinence to safer use to managed use (The Harm Reduction Coalition, n.d.). Though harm reduction is most commonly used to address substance use, the approach applies to “any decisions that have negative consequences associated with them,” including encouraging safer sex, the use of clean needles for people who inject drugs, the use of clean razors for people who cut or self-harm, increasing exercise, and engaging in opioid substitution therapies (Logan, et al., 2010, p.201).

In addition to providing frontline services, peer support workers within the context of harm reduction model use a bottom-up approach versus top-down to influence agency policies and practices that best meet the needs of the clients served. Peers use their lived experience to shape the agency’s understanding of the population served.

**THE EFFECTIVENESS OF PEER RECOVERY SUPPORT SERVICES**

While federal investment through the Recovery Community Services Program and Access to Recovery SAMHSA grants have expanded peer recovery support services over the last decade (Ashford, 2018) the approach is still considered to be in its infancy, and therefore, evidence on its effectiveness is limited (Bassuk et al., 2016). Bassuk et al. conducted a systematic review of studies on peer support services serving adults with alcohol or drug use problems. Nine studies met the criteria for inclusion and were reviewed. The review examined substance use outcomes, including abstinence and/or a decline in substance use as well as other recovery outcomes, including housing stability, increased access to primary care and fewer hospital/ER/detoxification admissions, probation/parole status. Most studies reviewed showed that participants receiving peer intervention services showed improvements in substance use, a range of recovery outcomes, or both (Bassuk et al., 2016). While the evidence supports the effectiveness of the approach, additional research is necessary to better understand the specific intervention components such as context, dose, and reach of the program, skill-level of the peer, and effectiveness among different populations.
CHALLENGES OF PEER RECOVERY SUPPORT SERVICES

A review of the literature suggests that the use of peers to support addictions recovery and behavioral health present challenges in the following domains: work environment challenges and individual challenges.

WORK ENVIRONMENT CHALLENGES

Challenges faced in the work environment include struggles to integrate workers into the organizations with professionally credentialed staff (Alberta et al., 2012), struggles to find appropriate management support and supervision (Alberta et al., 2012); lack of clearly defined roles and responsibilities of the peer support worker (Eddie et al., 2019; Jack et al., 2018; Gruhl et al. 2016); and highly variable range of training protocols for peers (Eddie et al., 2019; Alberta et al., 2012).

A qualitative study of paid peer support workers in mental health recovery agencies found that work overload in the agency led to burnout and stress (Moran, 2013). Additionally, the study found that insufficient training, unclear job descriptions, establishing and managing peer helping relationships with clear boundaries and appropriate self-disclosure created discord (Moran, 2013). While the study categorizes challenges with boundaries and self-disclosure as a work-based and training issue, it also can be classified as an individual challenge.

INDIVIDUAL CHALLENGES

Intrapersonal challenges faced by peer support workers included the struggle to navigate new professional roles and work expectations (Alberta et al., 2012); ethical concerns arising from boundary issues (Jack et al., 2018); and concerns involving self-disclosure (Gruhl et al. 2016). Moran’s study of paid peer support workers in mental health recovery agencies also identified that feeling overloaded and distressed led to intrapersonal challenges such as “taking worries home” and feeling impacted by “hearing negative experiences” similar to their own (Moran, 2012, p.287). The study also revealed that peer support workers experienced a reemergence of their own mental health symptoms due to increased exposure to the mental illnesses of participants (Moran, 2013).

EVALUATION GOALS AND PLAN

As a requirement of the SAMHSA grant, Open Aid Alliance sought to review program progress via an externally contracted local performance assessment. The overarching goal of the performance assessment is to measure progress in achieving the goals, objectives and outcomes set forth by the SAMHSA BCOR grant proposal. The assessment focuses on both program outcomes and implementation process.

The performance assessment seeks to measure intended impact, including increasing access to high quality peer support services, and impact on clients as a result of recovery support services. Program successes, barriers encountered, and efforts to address barriers will be highlighted. Data from the assessment will inform program improvements and refinements as the program heads into year two of the grant.
The Kellogg Foundation (2017) highlights that a process evaluation does the following:

- "Seeks to understand if a strategy, initiative or program is being implemented as planned and according to schedule.
- Assesses if the effort is producing the intended outputs.
- Identifies strengths and weaknesses of the effort" (p.29).

The evaluation plan specifically focuses on the implementation of the program to identify critical program components that contribute to the program success or create barriers to implementation. Specifically, the implementation focus includes the following areas:

- identify and minimize barriers to implementing activities;
- measure the community’s perceptions of the program;
- monitoring clients’ and other stakeholders’ experiences with the project, and their satisfaction with and utilization of project services (Kellogg, 2004, p. 25).

OUTCOME EVALUATION

Outcome evaluations are designed to assess the effect of an intervention. SAMHSA requires programs to enter National Outcome Measures (NOMs) into the Performance Accountability and Reporting System (SPARS) at client intake, after six months of program participation, and at discharge. The NOMS, also identified as the performance indicators include abstinence, stability in housing, employment and educational status, crime and criminal justice status, health/behavior/social consequences, social connectedness, and recovery support. Data on these indicators are to be collected at intake, at six months, and at discharge. A positive rate of change is expected in all measures except social connectedness.

While it was one of the original goals of the performance assessment to collect and analyze this data, peer support staff changes, including 100% position vacancies in the program during this assessment negatively impacted data collection. Suggestions to improve and sustain data collection and enhance future outcome evaluations are included in the Recommendations section of this report.

DATA COLLECTION PLAN

The original evaluation plan included a mixed method approach to gathering data. Though the plan was to gather quantitative data via available SPARS quarterly reports, limited data entry due to staff turnover created barriers to this approach. As a result, data collection focused exclusively on qualitative data collected through individual semi-structured interviews and focus groups.

A nonrandom, purposive sampling method was used to select interview and focus group participants. With the guidance of the OAA Executive Director (ED) and the Uncovery Peer Support Recovery Coach (PSRC), four main target populations were selected for this program evaluation:

1) Open Aid Alliance Staff including the
   a) the ED,
   b) Uncovery Clinical Director, and c) other OAA staff as selected by the OAA ED and PSRC;

2) Uncovery Peer Support staff, including:
   a) the Peer Support Recovery Coach,
   b) the Peer Support Specialist, and c) the Peer Support Clinical Supervisor;

3) Community partners who refer to and/or coordinate with the OAA peer support program; and

4) Clients utilizing Uncovery peer support services.

While it was the original plan to interview the two staff that comprise the Peer support program (Peer Support Recovery Coach and the Peer Support Specialist), both individuals left their positions during the time period of this evaluation. The Peer Support Recovery Coach was employed at the start of the evaluation process and helped inform both the interview questions and the specific individuals, including staff and community members to be interviewed.
## QUALITATIVE DATA

### EVALUATION TOOLS

The following outlines the evaluation tools used:

<table>
<thead>
<tr>
<th>TOOLS</th>
<th>DESCRIPTION OF TOOL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semi-structure interviews</td>
<td>Semi-structured interviews were developed in partnership with the OAA Executive Director and the Uncovery Peer Support Recovery Coach. The evaluator interviewed individuals from the following main target areas:</td>
</tr>
<tr>
<td></td>
<td><strong>GROUP #1: OPEN AID ALLIANCE STAFF</strong></td>
</tr>
<tr>
<td></td>
<td>1. Executive Director (1)</td>
</tr>
<tr>
<td></td>
<td>2. Uncovery Clinical Director (1)</td>
</tr>
<tr>
<td></td>
<td>3. OAA staff (2)</td>
</tr>
<tr>
<td></td>
<td><strong>Total # 4 individuals</strong></td>
</tr>
<tr>
<td></td>
<td><strong>GROUP #2: UNCOVERY PEER SUPPORT STAFF</strong></td>
</tr>
<tr>
<td></td>
<td>1. Peer Support Recovery Coach Position vacant – did not interview</td>
</tr>
<tr>
<td></td>
<td>2. Peer Support Specialist Position vacant – did not interview</td>
</tr>
<tr>
<td></td>
<td>3. Peer Support Clinical Supervisor 1 interview</td>
</tr>
<tr>
<td></td>
<td><strong>Total # 1 individual</strong></td>
</tr>
<tr>
<td></td>
<td><strong>GROUP #3: COMMUNITY PARTNERS THAT REPRESENT THE FOLLOWING AGENCIES</strong></td>
</tr>
<tr>
<td></td>
<td>1. Criminal Justice—Probation and Parole (1)</td>
</tr>
<tr>
<td></td>
<td>2. Criminal Justice – Treatment Court (1)</td>
</tr>
<tr>
<td></td>
<td>3. Housing –shelter and homeless outreach team (1)</td>
</tr>
<tr>
<td></td>
<td>4. Housing – shelter (1)</td>
</tr>
<tr>
<td></td>
<td>5. At Risk Housing Coalition (1)</td>
</tr>
<tr>
<td></td>
<td><strong>Total # 5 individuals</strong></td>
</tr>
<tr>
<td></td>
<td><strong>GROUP #4: PARTICIPANTS UTILIZING UNCOVERY PEER SUPPORT SERVICES.</strong></td>
</tr>
<tr>
<td></td>
<td>1. Participant individual interview (1)</td>
</tr>
<tr>
<td></td>
<td>2. Participant individual interview (1)</td>
</tr>
<tr>
<td></td>
<td>3. 2-person focus group (2)</td>
</tr>
<tr>
<td></td>
<td><strong>Total # 4 individuals</strong></td>
</tr>
</tbody>
</table>

Participants of the Uncovery Peer Support Program were invited to participate in a focus group to share input on 1) program implementation process and 2) program impact.

Participants who volunteer received a $10 gift card to a local grocery store provided by OAA.

Due to participant availability, data was collected via two individual interviews and one two-person focus group.
GOALS FOR EACH TARGET GROUP

Target group #1: OPEN AID ALLIANCE STAFF

GOAL 1: Identify the impact of the Uncovery Peer Support Program on peer support workers, program participants, and the agency at large

GOAL 2: Identify barriers to implementing program activities

Target group #2: UNCOVERY PEER SUPPORT STAFF

GOAL 1: Identify the impact of the Uncovery Peer Support Program on peer support workers and program participants

GOAL 2: Identify barriers to implementing program activities

GOAL 3: Assess if the program is implemented as planned

Target group #3: COMMUNITY PARTNERS

GOAL 1: Identify community partners’ perception of the program, including perceptions and feedback on the referral process

GOAL 2: Gather feedback on ways to improve the program

Target group #4: PARTICIPANTS UTILIZING UNCOVERY PEER SUPPORT SERVICES.

GOAL 1: Assess participants’ experiences with the program including their satisfaction with and utilization of services

GOAL 2: Identify strengths and weakness of the overall effort

ANALYSIS

The primary evaluator contracted with two additional researchers to assist with analysis. The research team relied on core principles of qualitative analysis to identify themes among the target groups. Following the guidelines for thematic analysis set out by Braun and Clarke (2006), each researcher independently reviewed transcripts of the interviews and identified initial codes, patterns and themes within each data set. Researchers met frequently throughout the initial coding to discuss emerging themes for each target group. After all of the coding was complete, researchers met and created a final coding system.

LIMITATIONS

The following lists the primary limitations of the evaluation.

Peer Support Worker Turnover and Position Vacancy

As previously indicated, the two staff for the Uncovery Peer Support Program left their positions within the first month of launching the program evaluation. The Peer Support Recovery Coach was present to assist with the development of interview and focus group questions, yet the primary goals of Target group #2 remain unaddressed. Included in the analysis is input from the Uncovery Clinical Supervisor, a position held by a clinician external to the agency. Because the Uncovery Clinical Supervisor was the only interview conducted from Target group #2, data from this interview has been combined with the analysis of Target group #1: Open Aid Alliance staff. It should be noted that the Uncovery Clinical Supervisor is a contractor versus an employee; however, the role serves as an insider-outsider perspective in witnessing the program similar to other agency staff. The analysis does not include input from the Uncovery peer support workers on the impact of the Uncovery Peer Support Program on peer support workers, the barriers to implementing program activities, and the fidelity to program as planned from the critical perspectives of staff running the program.

Inconsistent Data Entry

An additional limitation in this program evaluation is the scarcity of outcome data available. As previously mentioned, the significant staff turnover impacted data entry. Also, there appears to have been limited training and oversight in terms of data entry.

RESULTS

The following section includes the key results of the evaluation organized by the target groups.

Target group: Open Aid Alliance Staff

As previously indicated, Target group #2, Uncovery Peer Support staff has been collapsed into Target group #1 because only one person, the outside Clinical Supervisor, was interviewed.
The following chart highlights themes that emerged from the Open Aid Alliance staff interviews.

<table>
<thead>
<tr>
<th>THEME #</th>
<th>THEME STATEMENT</th>
<th>STRENGTH/CHALLENGE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>THEME 1</td>
<td>Lived experience builds trust and safety</td>
<td>Program Strengths</td>
</tr>
<tr>
<td>THEME 2</td>
<td>Peer support workers are the connection point to supportive services and to personalized treatment options which aid in recovery</td>
<td>Program Strengths</td>
</tr>
<tr>
<td>THEME 3</td>
<td>Insufficient program policies and procedures limit program success and stability</td>
<td>Program Challenges</td>
</tr>
<tr>
<td>THEME 4</td>
<td>The roles and responsibilities of the Peer Support workers are unclear</td>
<td>Program Challenges</td>
</tr>
<tr>
<td>THEME 5</td>
<td>Peer support workers struggled to maintain appropriate professional boundaries</td>
<td>Program Challenges</td>
</tr>
</tbody>
</table>

**PROGRAM STRENGTHS**

In uncovering the impacts of the program on peer support workers, program participants, and the agency at large, two primary themes emerged.

**THEME 1:**
The peer support workers’ lived experience with addiction and recovery inherently builds trust and safety with participants. These relationships form the bedrock in which to administer and receive support services.

> “I think it reduces the hurdles to accessing care... There’s a certain camaraderie and comfort in talking to a peer versus somebody more professional.” — OAA staff

> “There is something really powerful about getting support and help from someone who may not have the exact same experience, but have a shared experience, including experience with trauma, who also struggles with filling out paperwork; they get the challenge. Peers have found a way to cope with that and get through it. Because of shared experience, participants are not going to feel that shame. Participants are open to that support.” — OAA staff

**THEME 2:**
Peer support workers are the connection point to supportive services and to personalized treatment options which aid in recovery.

Once the relationships based on trust and safety are established, peer support workers serve as a connection point to recovery. In their roles, they connect participants via warm handoffs to supportive services within the agency (i.e., housing assistance, addictions treatment, and STI testing), and supportive services outside the agency (i.e. primary care, Medicaid enrollment, and employment assistance).

Additionally, the peer support workers serve as the connection point to explore personalized treatment and recovery options. Both the supportive services and the explicit connection to treatment expands the pathway to recovery.

> “Peers are the connection to whatever recovery services participants might need. Peers are there to lead them to services, both in and outside of the agency.” — OAA staff

> “To provide care based on lived experience. To increase access to care. To have an ally to navigate places a client needs help that have to do with kind of these offshoots of recovery. It could be about recovery, but all the steps in recovery like legal affairs or getting to a doctor’s appointment, like having an ally in these processes. Having someone go with you to appointments if there’s a barrier. Having an advocate, like especially in court.” — OAA staff

> “I think it helps give someone a connection point to discuss their addiction in a way that is frank, using the language they are comfortable with, a language they use every day.” — OAA staff
Creating deeper relationships with participants and formalizing connections to supportive services and treatment options shifted the entire agency’s approach to and depth in serving participants:

“I noticed immediate changes in the way that participants interacted with our agency after we had peer support. Before peer support, it was, ‘come in, get what you need, small talk, leave.’ After peer support, there was a lot more spending time in the office, a lot more time addressing other needs, that true wrap-around model...I think people feel more connected. A syringe exchange program can be a grocery store shop. Or, it can be like a co-op. It felt like that was the change. There was a lot more, ‘I belong here.’” — OAA staff

PROGRAM CHALLENGES
Open Aid Alliance staff identified challenges associated with limited program infrastructure. The following highlights the primary program infrastructure challenges noted by staff.

THEME 3:
Insufficient program policies and procedures limit program success and stability
As a new program to the agency, Uncovery Peer Support Program lacked sufficient policies and procedures to support the program operations. Instead, policies and procedures emerged in reaction to the challenges faced by peers and other Open Aid Alliance staff. As one staff articulated, “you can commit (to launching a new program) on paper, and then doing it is another experience all together.”

Launching the Peer Support program was new terrain for the agency, and as a result, unexpected challenges arose forcing the agency to reactively create policies for scenarios they previously could not have imagined.

“We didn’t have a policy for using substances in a hotel when travelling for work. Or, what to do when you find a bag of weed on the ground. Or what to do when a participant hands you a gun, and says can you hold this for me? What to do when a participant brings you every CPS (Child Protective Services) document she has ever been given and she says, will you keep this until my case is finished?” — OAA staff
THEME 4: The roles and responsibilities of the Peer Support workers are unclear
Interviews with staff also revealed confusion over the role of the peer support worker. While staff consistently reported valuing the role of the peer worker to engage with and serve participants, the lack of clarity on the parameters of the peer support worker job, including how the role overlaps and differs from other positions such as case management at the agency, the delineation between sponsor and mentor roles, and different standards of professionalism created discord.

“Okay, so you’re going to have to decide if you want this person to be your sponsor or your peer supporter. You can’t have a dual role.” -- OAA staff

“For me, trying to really understand what a peer meant versus case management, and really respecting that boundary. Not treating a peer as a case manager or expecting them to use my language. There was definitely some boundary building I had to address for myself with them, respecting their position as well.” -- OAA staff

THEME 5: Peer support workers struggled to maintain appropriate professional boundaries
Similar to the participants served at the agency, peer support workers entered into their professional roles in the agency with complicated histories with addiction and recovery. While this lived experience was seen as an important asset to building safe and trusting relationships with clients, staff agreed that it blurred professional boundaries.

“It was really hard for them to maintain boundaries. It was hard for them to follow work policies... to adhere to boundaries and not go off and do the exact opposite. I also think they were both challenged with kind of the savior complex. Like it was their job to save and rescue people and to be this hero, and so that would also influence crossing boundaries or going above and beyond what they needed to do, and then it made it personal if they couldn’t do that or if they went too far” -- OAA staff

Another staff believed that poor boundaries from peer support staff led to overpromising and under delivering on services offered to participants. The staff believed that lived experience can blur the separation between participant and professional and friend.

Additionally, staff noted the smallness of the recovery community. It is not uncommon for peers to have relationships with participants prior to their roles as peer support workers further complicating professional boundaries.

Finally, poor professional boundaries could have also been the result of limited professional work experience.

One OAA staff noted the following:

“One of them in-particular, this was his first time having a real job, and so that navigating the personal and the professional was really hard. There’s this certain amount of space that they are working from their personal story versus like academia or education. It was hard to find where the boundary was between personal and professional, and so a lot of their personal would spill over into work.”
TARGET GROUP: COMMUNITY PARTNERS

Community partners that represent the criminal justice system and the local housing systems provided insights on their perceptions of the program and ways to improve interagency collaboration. Perceptions of the program were strongest when community partners understood the purpose of the program and when communication between agencies was consistent. Interagency collaboration was strongest when the harm reduction philosophy aligned with or at least did not contradict with the partnering agency’s model of care.

<table>
<thead>
<tr>
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<th>STRENGTH/CHALLENGE?</th>
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</thead>
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<tr>
<td>Theme 1</td>
<td>A solid understanding of program approaches (harm reduction and peer support models) reinforced by consistent communication led to a positive overall perception of the program</td>
<td>Program Perception</td>
<td>Program Strength</td>
</tr>
<tr>
<td>Theme 2</td>
<td>Concerns about peer support worker professionalism impacted program perception</td>
<td>Program Perception</td>
<td>Program Challenge</td>
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<tr>
<td>Theme 3</td>
<td>OAA’s harm reduction approach is both a facilitator and a barrier to interagency collaboration</td>
<td>Interagency Collaboration</td>
<td>Program Strength and Challenge</td>
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</table>

THEME 1:
A solid understanding of program approaches reinforced by consistent communication led to a positive overall perception of the program

Community partners who understand harm reduction and peer mentor approaches appreciated the agency’s unique opportunity to serve the area’s most vulnerable citizens. Informed partners described the service as “a support system to come alongside someone who wants to be in recovery,” a “safe place for active users,” and that peer support workers use their “lived experience to form connections” that allow them to “work alongside people to help them in recovery.” Community partners’ description of peer support within a harm reduction model similarly highlights the program benefits as described by OAA staff.

Additionally, community partners who either worked alongside peer support workers in street outreach and/or who received good communication from the workers maintained a positive perception of the program.

“Like I said, I think the biggest thing is the communication and they’re actually better than most of my partners. The peer support worker would reach out to me...So I think that’s tremendously helpful when you have that open communication and that interagency understanding of what the true goals of both people are. And that’s to help people be successful.” —Community partner

Street outreach done in collaboration with peer support workers improved the perception of and referral to the program. An outreach worker at a collaborating agency reported that warm handoffs done on the streets allowed both agencies to expand their reach and increase access to supportive services. The community partner noted, “when we already have a relationship with somebody and are trying to get them into services, we’ll usually warm handoff out on the streets so they don’t have to come to a building. So we’re meeting them where they’re at, in a more comfortable territory for them and obviously kind of doing it in a, ‘Hey, I’m just going to introduce this person and we’ve talked about them before, but if you feel inclined to get to know them,’ and then they go from there.” The interagency relationship is stronger when services are done in collaboration and when the agency goals are shared.
THEME 2:
Concerns about peer support worker professionalism impacted program perception
Concerns about peer support professionalism including a lack of common professional skills and a lack of follow-through impacted agency’s perception of the program.

“I witnessed issues with professionalism—missing meetings, emails with poor grammar and being told that one of the peer workers was uncomfortable using technology. I had read a letter that one of the peer workers had written on behalf of a client they were working with; it was a reference letter that was going to be submitted in their housing portfolio to prospective landlords. It had a lot of spelling and grammatical errors; it seemed very unprofessional and not credible.” -- Community partner

Lack of follow-through and unfulfilled promises from the peer support worker impacted agency perception. One community partner reported, “The (peer support worker) unfortunately did promise some things that they weren’t able to come through for as far as funding assistance, things like that. Which was difficult for (the participant) because when you’re told your people are going to do something and then they don’t, you lose some credibility.”

THEME 3:
OAA’s harm reduction approach is both a facilitator and a barrier to interagency collaboration
In community agencies where abstinence is a required condition of participation, OAA’s harm reduction approach either enhanced or complicated the collaboration. Several community partners indicated that a warm handoff to OAA’s Peer Support Program meant that individuals actively using substances can continue to be served in the community. For example, the local temporary housing shelter is a dry shelter; residents who are under the influence of drugs and/or alcohol are not eligible for services. During street outreach, a referral to OAA widens the housing support and associated supportive services for individuals who are actively using substances. It expands their pathway to supportive services that can aid recovery.

For other agencies, the harm reduction model is incongruent with the abstinence model that informs their program. Because the program is based on an abstinence-model, one partner noted, “it was really difficult to put my clients in a position where they were around other people who were still not in recovery; they were still using and that really put them in a compromising position sometimes.” This comment also speaks to the vulnerability of the recovery process for both program participants and peers. Exposure to active users can be a challenge for participants who must maintain sobriety due to court mandates, but also to peer support workers. The community partner went on to state, “As far as when a (peer support worker) relapses, there has to be an instantaneous reaction, and there has to be very clear boundaries that you cannot have someone who has relapsed continue to coach. The person that they’re coaching is going to go down with them.”
TARGET GROUP: PARTICIPANTS UTILIZING UNCOVERY PEER SUPPORT SERVICES

Participants utilizing Uncovery Peer Support Services provided insights on their experience with the program including their satisfaction with and utilization of services. The themes are organized into factors that contribute to beneficial peer support worker – participant relationships and factors that challenged participants’ recovery and/or their utilization of services.

The following charts highlights themes that emerged from interviews with clients who utilize the Uncovery Peer Support Services.

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<td>Program strengths</td>
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<td>THEME 3</td>
<td>Group support allows participants to give and receive support to others.</td>
<td>Factors beneficial to peer support worker–participant relationship</td>
<td>Program strengths</td>
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<td>THEME 4</td>
<td>Recovery is delicate.</td>
<td>Factors impacting recovery and/or their utilization of services</td>
<td>Program challenges</td>
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<tr>
<td>THEME 5</td>
<td>Blurred professional boundaries complicate the peer support worker–participant relationship.</td>
<td>Factors impacting recovery and/or their utilization of services</td>
<td>Program challenges</td>
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Factors that contributed to a beneficial peer support worker–participant relationship

**THEME 1:**

Shared lived experience leads to emotional safety, increased accessibility and a greater understanding of the recovery process. Similar to the theme identified by OAA staff, shared lived experience with addiction and recovery creates an accessible entry point for developing trust and safety between the peer support worker and the participant. One participant explained that the shared lived experience with a peer support worker differs from the relationship built with a professional counselor. He stated, 

“(my peer support worker) went through it all, and that’s what was cool was that she would share her experiences too, you know? So you realize you’re not the only one... Having those counselors that are not alcoholics and addicts and they know the terms and this and that, which is fine, but they’ve never been through it.”

Additionally, the shared lived experience creates emotional safety that led to feelings of unconditional acceptance for the recovery process.

“I could be totally honest with (my peer support worker) and not feel embarrassed or like I’m being judged and that’s a big thing.” — Program participant

“I’ve had a few slips and I was really desperate and didn’t know what to do. And I called (my peer support worker) and she was just, you know, she’s like, ‘look, you’re doing the right thing, you’re reaching out.’ And she pointed out a bunch of stuff and then I started realizing, hey, the old me would not have done this, he would not have reached out for help.” — Program participant

Though it is unclear if it is the shared lived experience of peer support, the harm reduction model, or a combination of both, peer support is perceived by participants as being more accessible than other forms of treatment and support. A consistent statement made by many of the participants was that peer support workers meet participants ‘where they are.’ For example, one participant stated, “(Peer support workers) just meet you where you are at. And wherever you are at, it is okay by them. So, that is comforting. You do not have to jump through hoops to get to anyone. They are just ready for you wherever you are at. That is comforting.”
Additionally, participants noted the accessibility of peer support workers in terms of their availability to respond to participant needs. Participants appreciated being able to seek support from a peer support worker via the phone and/or in the OAA office when needed.

“*It didn’t matter what time of day or night it was; I could call (the peer support workers). They are always there no matter what, and I can talk to them.*”  – Program participant

Comparing Uncovery peer support to other forms of recovery supports, participants noted the following:

“*I felt comfortable, which like if I go to AA, I don’t feel comfortable and I shy away and I don’t want to speak. I felt comfortable and accepted there.*”  – Program participant

“I am not into AA. I don’t want to hear people’s horror stories. I’ve got a million of them myself. So, in the meeting at the 4D club, there’s more drugs in that meeting...It’s a place to hook up, to get more drugs.”  – Program participant

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**THEME 2:**
**Peer support workers link participants to supportive services within and outside the agency**

Participants expressed the value of the peer support worker as a conduit to supportive services that aided their stability and recovery. Supportive services include medical support, housing support, assistance with the legal system, family support, and assistance with transportation.

In terms of the link to OAA services, one participant stated, “We use all the services. I’ve used the mailbox to their bathroom to the needle exchange. We have used their clothing closet. Whatever they let us use, we use. We have used them to their fullest capabilities. They have really helped us a lot when we were using and not using.”

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**THEME 3:**
**Group support allows participants to give and receive support to others**

Several participants noted the value of being a role model to other participants in the group setting. Individuals noted that sharing their recovery stories with other participants reinforces their sobriety.

“The most helpful thing was when (the peer support worker) would ask me to come into group to be a mentor. And, that’s helpful for me to tell my story and help people who are just coming in, and don’t really know what they are doing or how it works.”  – Program participant

Additionally, participants found the resource sharing among group members to be helpful.

“Yeah it would be like open forum. And those are really sometimes helpful because I remember we needed gas cards and somebody told us where to get them, and it worked out.”  – Program participant
THEME 4: Recovery is delicate. Exposure to intoxicated participants and/or peer support workers who relapse challenge the recovery of participants.

The vulnerability and delicate nature of recovery was a theme expressed among the program participants. One participant shared, “As strong as my armor is, I’m only one use away from relapse.” When asked about the philosophy of harm reduction, participants agreed that “addicts slip,” and that their own recoveries have been far from a linear process. One man shared his appreciation for the model stating, “I’ve been a junkie for a long time. I had 10 years clean and I relapsed for a year, and then now I have two years clean. I’m 50 and that only allots for 12 years. The rest of that time from the time I was about 16 to whatever 12 years ago was, I was getting high.” However, at the same time, the same participant shared the challenge of being exposed to intoxicated group participants. This was particularly challenging, because for some, abstinence is a condition of their criminal justice and/or child protective services compliance. For these participants, the harm reduction approach was not a seamless fit.

As previously mentioned, this evaluation does not include the perspectives of the peer support workers who launched the Uncovery Peer Support Program because they were no longer employed at the agency during the interview phase of this evaluation. Because of the absence of their perspectives, this report cannot elaborate on the vulnerability peer support workers faced in sustaining their own recovery programs when serving actively using participants. The interviews did, however, uncover the impact on participants when they learned of peer support worker relapse. One individual stated, “it is tough when it is someone you look up to. I know for new people in recovery, it makes them feel like, ‘what’s the point?’ If this person has been in recovery this long and they are doing this shit, why would I go through recovery?” I mean, I am passed that, I understand relapse, and stuff like that. I can imagine for others it is a lot harder for her to see that.”

THEME 5: Blurred professional boundaries complicates the peer support worker-participant relationship

Several of the participants interviewed noted the smallness of the recovery community, and stated that previous personal relationships with peer support workers led them to the agency. While it was identified as a helpful referral conduit, previous personal relationships may have blurred professional boundaries and impacted confidentiality. To illustrate the crossing of boundaries a participant stated, “Random things would come out in the air that should only be known by one person, and you are wondering how that information got out there. Obviously, someone somewhere crossed the boundary and didn’t respect something they should have. And, that gets hard.”

DISCUSSION

The program strengths identified by OAA staff, community partners, and program participants align with the benefits highlighted in the literature. Well-executed peer recovery support services have the potential to expand the pathway to recovery. Once relationships based on trust and safety are established, peer support workers serve as a connection point to recovery, including a connection to supportive services within and outside the agency, and a connection to individualized treatment options. The result is a pathway to recovery that is led by the participant and reinforced by the peer support worker.

Both community agencies familiar with the agency’s model of care and OAA staff see harm reduction as a facilitator to increasing access to care. Harm reduction opens the door for a range of substance users; thereby increasing the options for and pathway to recovery. Essential to recovery is not only substance use treatment, but also access to supportive services such as housing and medical care. Bassuk et al. (2016) highlight the importance of additional recovery outcomes such as housing stability, increased access to primary care and fewer hospital/ER/ detoxification admissions, stable probation/parole status as essential building blocks in the recovery pathway.

While the agency has committed to the peer support model of care to better serve their population, to increase access to recovery support, and to better live out their mission of working with “the unique potential of each individual to overcome stigma as they seek greater health” (OAA Mission, n.d.), walking the talk comes with challenges and growing pains.

As one OAA staff shared, committing to the peer support model has been a hard, yet mission-enhancing move for the organization.

“It has made us better. Better because it is such a good experience. Getting to know our population on a different level. They are our employees and they represent the people we serve. So, you get to see the real deal. And that commitment – we are not just a bunch of people with college degrees serving others—We are actually committed to this other model. To working alongside others. It is hard as hell.”

With continued commitment to refining the program, OAA can serve as a leader for peer support programs in Montana.
PROGRAM CHALLENGES

Using lived experience to build relationships offers the opportunity for safe connections AND blurs professional boundaries. The relatability of peer support workers to the participants creates a shared understanding, and yet, the absence of professional boundaries can lead to peer support worker burnout, poor follow-through, miscommunication, and role ambiguity. Professional boundaries are most easily maintained when professionals limit personal disclosure. Yet, the essence of the peer support worker relationship is built first on shared lived experience. OAA staff and participants articulated the challenges of blurred boundaries and unclear roles, and the literature similarly highlights this as a common challenge in peer support programs (Eddie et al., 2019; Jack et al., 2018; Gruhl et al. 2016).

Researchers stress the importance of ongoing training and supervision to help workers navigate their emotionally taxing and, at times, ambiguous roles. Moran et al. (2013) suggest developing ongoing training that specifically focuses on developing skills to leverage self-disclosure in a meaningful and value-added way. They suggest, “developing one’s life narrative from a genuine personal recovery perspective, weighing the advantages and disadvantages of disclosure, role play training, and supervised practice in real life situations” (Moran et al., 2013, p.289). This skill development takes practice and it requires supportive and reflective supervision.

Peers for Progress, a program of the American Academy of Family Physicians Foundations (2015) suggest the following characteristics of good supervision and support for peer supporters:

1. **Ongoing support**: Routine, structured check-ins, 24/7 back-up and information check-ins that occur regularly over time.

2. **Regular check-ins**: Examples include: weekly group teleconference with project coordinator and other peer supporters; one-on-one, biweekly face-to-face meetings with project coordinator; monthly one-on-one with the project staff and other peer supporters.

3. **Back-up support**: Offering peer supporters the contact information of their supervisors.

4. **Continuing education and on-the-job training**: Enriching peer supporter skill sets and providing opportunities for personal advancement.

5. **Supportive supervision**: Two-way communication that is constructive, motivational, and reflective of the peer supporter’s value added in a collaborative work relationship (p. 53).

Additionally, Peers for Progress, states that “peer support humanizes care” (2015, p.1). Because of the critical role peer support workers have in opening doors for individuals who may have been previously disconnected from services, the agency care for peer support workers must be well-established.

The agency’s insufficient programs policies and procedures is a challenge similarly experienced by other programs and highlighted in the literature (Bassuk et al., 2016). It is impossible to get everything right when planning a new program. While organizational and community readiness assessments can prepare the agency for implementation, unexpected roadblocks are still to be expected. A quality improvement model such as the Rapid Cycle Improvement model, also referred to as Plan-Do-Study-Act (PDSA) model, is a suggested approach to learning and improving agency processes. The four-step model consists of the following: clarifying intervention objectives, executing the intervention, studying the impact of the intervention, and acting on lessons learned to improve the intervention (Peers for Progress, 2015). It is an ongoing process that helps to cultivate a spirit of inquiry and continuous improvement within a program.

To improve role clarity of the peer support worker, Davidson et al. suggests a “clear job description and role clarification — fully endorsed by key stakeholders (including program administrators, supervisors, and potential coworkers) — with relevant competencies, and a clear policy for evaluating competencies and job performance” (2013, p. 127). Role clarity should be defined in the job description, and should be revisited regularly as roles and responsibilities may evolve.
RECOMMENDATIONS
The following recommendations are presented as strategies for enhancing the strengths of the program and mitigating the challenges:

FINDING 1: Shared lived experience creates a safe and trusted peer support-worker – participant relationships which thereby increases access to supportive service.

RECOMMENDATION 1A: Clarify the roles and responsibilities of the peer support worker, identify the role overlap and the role differentiation between case management and counseling roles in the agency.

RECOMMENDATION 1B: Increase the capacity of peer support workers by improving supervision and ongoing training. Implement and/or enhance the following: a) schedule regular check-ins, b) create back-up support, c) provide continuing education and on-the-job training, d) commit to and implement supportive supervision. Additionally, develop a training program specifically focused on developing skills to leverage self-disclosure in a meaningful and value-added way.

RECOMMENDATION 1C: Support the recovery of peer support workers. Create a policy to support relapse, clarify substance-use-on-the-job policies and encourage continued recovery support for peer support workers.

FINDING 2: Peer support workers link participants to resources within and outside the agency that support recovery

RECOMMENDATION 2A: Further train peer support workers to become systems navigators that can link participants to critical supportive services. Combine lived experience with professional systems navigation skills to help broker essential services.

RECOMMENDATION 2B: Track both referrals to supportive services and follow-up with recommended supportive services to better track recovery outcomes.

RECOMMENDATION 2C: Connect peer support worker with key coordinators at collaborating community agencies to build partnership, communication, and service coordination.

FINDING 3: OAA’s harm reduction approach is both a facilitator and a barrier to interagency collaboration

RECOMMENDATION 3A: Develop a community advisory board to help educate the community on the opportunities and limitations with the harm reduction model. Use the community advisory board as a way to clearly communicate the role of the peer support workers and the hours of services, to promote the critical services provided to the community, and to troubleshoot challenges with interagency collaboration.

FINDING 4: Insufficient program infrastructure limits program success and stability

RECOMMENDATION 4A: Co-create program policies and procedures with staff to stay consistent with the peer support model. Revisit bi-annually via a Rapid Cycle Improvement Approach. Revise as needed.

RECOMMENDATION 4B: Commit to consistent and thorough program data collection to ensure program fidelity, program improvement, compliance with SAMHSA guidelines, and to secure additional funding. See Appendix C for strategies to improve data collection.

RECOMMENDATION 4C: Continue to systematically collect participant feedback on program components (i.e. Groups, one-on-one support, referral) and use feedback to improve efforts.
APPENDIX

A. REFERENCES
B. INTERVIEW QUESTIONS
C. STRATEGIES TO STREAMLINE THE DATA COLLECTION PROCESS
D. LOGIC MODEL
APPENDIX A: REFERENCES


Open Aid Alliance (2017) SAMHSA Comprehensive Addiction and Recovery Act: Building Communities of Recovery Grant Application.


APPENDIX

APPENDIX B. INTERVIEW AND FOCUS GROUP QUESTIONS

The following list questions for each of the four target groups

TARGET 1: UNCOVERY PEER SUPPORT STAFF
- Project Coordinator/Peer Support Specialist
- Peer Mentor
- Clinical Supervisor (questions adapted for clinical supervisor)

PROGRAM IMPACT:
For participants—
1. From your perspective, what are the biggest benefits of the Uncovery peer recovery program for participants?
2. How does the Uncovery Peer Recovery program help individuals with substance abuse and addiction?
3. What unexpected outcomes, if any, have resulted from participants’ involvement in the Uncovery peer recovery?

For peer mentors:
4. What are the biggest benefits of the Uncovery peer recovery program for peer mentors?
5. Describe the ways you are involved in program development?
6. Describe the ways you are involved in program implementation?
7. Describe the ways you are involved in decision making?
8. Have you provided feedback on the program to the organization?
   If yes,
   a. How do you give feedback?
   b. How is this feedback incorporated?

PROGRAM IMPLEMENTATION
Peer engagement
9. What are the primary goals of the Uncovery peer recovery program?
10. What does a successful peer engagement relationship look like?
11. What factors contribute to a successful engagement of a participant into the program?
    Factors may include: characteristics of a participant, community support, OAA support, environmental factors such as weather or housing
12. What does an unsuccessful peer engagement relationship look like?
13. What factors contribute to an unsuccessful engagement of a participant into the program?
    Factors may include: characteristics of a participant, community support, OAA support, environmental factors such as weather or housing

Program fidelity
14. How does your program align with the goals of the MT Peer Support Network?
15. How is your program different from the MT Peer Support Network?
16. How has the program changed since you first launched the program?
17. Are there ways that the program can be changed to be more effective for participants?

Trainings and preparedness for the role
18. What training from the MT Peer Support Network and/or outside trainings have been most helpful to you in your role as a peer mentor?
19. What additional training would improve your ability to serve participants well?

Referral / Recruitment
20. How are participants referred to your program?
21. How do you recruit participant?
22. What is your approach to recruiting priority populations? (The priority population includes people living with HIV, pregnant women, people with dependents, people experiencing homelessness, people reentering the community after incarceration, and people who use injection drugs)
23. What are the barriers to recruiting these individuals?
24. What advice do you have to improve outreach to these individuals?
Uncovery Clinical Supervisor

PROGRAM IMPACT:
1. What are the biggest benefits of the Uncovery peer recovery program for participants?
2. What are the specific ways the Uncovery Peer Recovery program helps people with substance abuse and addiction?
3. What unexpected outcomes, if any, have resulted from participants' involvement in the Uncovery peer recovery?
4. What are the biggest benefits of the Uncovery peer recovery program for peer mentors?
5. What are the ways peer mentors can be most effective in their role serving community members?

PROGRAM IMPLEMENTATION
6. What are the primary goals of the Uncovery peer recovery program?
7. What does a successful peer engagement relationship look like?
8. What factors contribute to a successful engagement of a participant into the program? Factors may include: characteristics of a participant, community support, OAA support, environmental factors such as weather or housing.
9. What does an unsuccessful peer engagement relationship look like?
10. What factors contribute to an unsuccessful engagement of a participant into the program? Factors may include: characteristics of a participant, community support, OAA support, environmental factors such as weather or housing.

TARGET 2: OPEN AID ALLIANCE STAFF
PROGRAM IMPACT:
1. What are the biggest benefits of the Uncovery peer recovery program for participants?
2. What are the specific ways the Uncovery Peer Recovery program helps individuals with substance abuse and addiction?
3. What unexpected outcomes, if any, have resulted from participants' involvement in the Uncovery peer recovery?
4. What are the biggest benefits of the Uncovery peer recovery program for peer mentors?

PROGRAM IMPLEMENTATION
Coordination of OAA Services
5. How does the Uncovery recovery program interface with your program?
6. What are the ways the Uncovery recovery program positively impacts your program?
7. What are the ways the Uncovery recovery program negatively impacts your program?

Peer engagement
8. From your perspective, what are the primary goals of the Uncovery peer recovery program?
9. What does a successful peer engagement relationship look like?
10. What factors contribute to a successful engagement of a participant into the program? Factors may include: characteristics of a participant, community support, OAA support, environmental factors such as weather or housing.
11. What does an unsuccessful peer engagement relationship look like?
12. What factors contribute to an unsuccessful engagement of a participant into the program? Factors may include: characteristics of a participant, community support, OAA support, environmental factors such as weather or housing.

TARGET 3: COMMUNITY PARTNERS
1. What do you know about the Uncovery Peer Recovery program at Open Aid Alliance?
2. What are the specific ways the Uncovery Peer Recovery program helps individuals with substance abuse and addiction?
3. Have you referred individuals to the Uncovery Peer Recovery program?
   - If YES:
     • why?
     • And, if yes, what was your experience referring a community member to the program?
   - If NO:
     • If you have not referred community members to the program, please share your reasons.
4. What suggestions do you have to improve the referral process to the Uncovery Peer Recovery program?
5. What comments/feedback have you heard about the program from other colleagues in your agency?
6. What comments/feedback have you heard about the program from other community agencies?
7. Is there anything else you would like us to know about your perceptions of this program?
TARGET 4: PARTICIPANTS USING PEER SUPPORT SERVICES

Focus group format and/or interview

Referral questions:
1. How did you hear about the Uncovery Peer Recovery program?
   a. If applicable, who referred you to the program?

Perceptions of the program:
2. What were your first thoughts about participating in Uncovery Peer Recovery program?
3. What is the program intended to do?

Program participation:
4. Why did you initially participate in Uncovery Peer Recovery program?
5. What keeps you coming back to the 1-on-1 meetings?
6. What do you get from participating in the program?

Perceptions of the program:
7. What do you enjoy most about participating in Uncovery Peer Recovery program?
8. What do you dislike?
9. What has been most helpful about participating Uncovery Peer Recovery program?
10. What has not been helpful?

Do you attend a peer support group?
If yes,…
11. Which topics presented have been most helpful?
12. What resources have been most helpful?
13. Have you used other services at OAA?
   a. If yes, which services?

Do you use 1-on-1 peer mentoring support?
If yes,…
11. Which topics presented have been most helpful?
12. What resources have you learned about that have been most helpful?
13. Have you used other services at OAA?
   a. If yes, which services?

Other:
11. Who do you think will be most successful in the Uncovery peer recovery program?
12. How can participants be most successful in using this program?
13. Who will struggle to participate in the Uncovery peer recovery program?
14. If someone you knew struggled with addiction, would you refer them to the program? Why or why not?
APPENDIX C: STRATEGIES TO STREAMLINE DATA COLLECTION PROCESS

General data entry
- Train new peers to interview and collect SAMHSA and agency data with the following in mind:
  - Articulate the importance of data as a tool to: 1) support clients and their recovery processes, 2) to continually improve the program, 3) secure funding, etc.
    - It may be helpful to go through each of the NOMs and articulate why each outcome measure matters
  - Role play / practice how to ask some of the more personal questions posed in the GPRA
- Formulate the workflow processes; see strategies below
- Review data as a team (Uncovery Peer Support Staff + OAA ED) every quarter to identify:
  - Program outputs (# of peers trained, # of people served)
  - Program outcomes (is the program doing what you said it would do?, are you making a difference?)
  - Data collection process—what is working and what could be improved in terms of collecting and entering data?

GPRA data
Overview: National Outcomes measures (see chart below) to be collected at intake, six months and at discharge. GPRA data is then entered into SPARS and included in quarterly reports

Process:
1. Peers complete GPRA at intake with every peer program participant
2. Program Director (PD) enters all GPRAs into SPARS on Friday afternoons
   a. Timely entry into SPARS will allow PD to follow-up when data are missing, etc.

Peer Program Next Steps:
- Complete SAMHSA webinars on: 1) GPRA—SPARS, and 2) Increasing follow up rates
- GPRA—Clarify if paper is the only option or if there is online version that can be completed on the tablet
- Find out if the SPARS system issues alerts at 6 months post intake when it is time for individual clients to complete another GPRA?

Helpful tools:
- GPRA FAQs
- SAMHSA webinars

Daily Encounter Tool
Overview: Add additional questions to the EHR for the peer program to help better track outputs and outcomes.

Process:
Peers enter data into the EHR via a tablet at each participant encounter

Suggestions:
- Provide peers with tablets so that they can more easily enter data with each encounter
- Information to be added:
  - Referrals – using a check-box format, list the most common referrals within the agency and outside the agency
  - Follow-up on referrals
    - Add a question: Did you follow-up on any of the referrals identified at last encounter?
  - Formalize LOCATOR contact form/information
    - At intake, and potentially at each encounter, fill in locator information to facilitate easier follow-up

Peer Program Next Steps
- Purchase tablets??
- Add questions to EHR
- Finalize Locator form information to be completed at intake
- Clarify if EHR houses unique identifier information

Improving follow-up rates
Overview: SAMHSA indicates at target follow-up rate of 80% at 6 months post intake

Suggestions:
- LOCATOR forms completed at intake, and possibly revisited at each encounter
- Incentives ($5 grocery store cards) for follow-up
  - Provide at 3 months and at 6 months to encourage more consistency
NATIONAL OUTCOME MEASURES COLLECTED VIA GPRA

**ABSTINENCE**
Section B, Drug & Alcohol Use
Past 30-day use of alcohol, illegal drugs, misuse

**STABILITY IN HOUSING**
Section C, Family & Living Conditions
• Participant’s living situation
• Impact of drug use
• Status of participant’s children

**EMPLOYMENT & EDUCATIONAL STATUS**
Section D, Education, Employment & Income
• Education, employment, and financial resources

**CRIME AND CRIMINAL JUSTICE STATUS**
Section E, Crime & Criminal Justice Status
• Participant’s legal history

**HEALTH/ BEHAVIOR/ SOCIAL CONSEQUENCES**
Section F, Mental & Physical Health Problems & Treatment/Recovery
• Past 30 days mental and physical health
• Sexual practices
• Violence and trauma

**SOCIAL CONNECTEDNESS**
Section G, Social Connectedness
• Past 30-day use of social support/recovery

**RECOVERY SUPPORT**
• Section C, Family and Living Conditions
• Section D, Education, Employment, and Income
• Section F, Mental & Physical Health Problems & Treatment/Recovery
• Section G, Social Connectedness

**There needs to be a positive rate of change for all measures EXCEPT social connectedness,**

i.e. participant stopped using and his friend group changed
Problem Statement: There is a lack of access to substance use disorder (SUD) recovery support in the Health Region 5, which includes Missoula and six surrounding counties.

Goal: To increase access to SUD recovery-oriented services via a peer support – harm reduction program. The program is intended for residents in Health Region 5 with a particular focus on the area’s most underserved population: people living with HIV, people who inject drugs, pregnant women, people with dependents in the home, people who experience homelessness, and/or people who are reentering the community after incarceration.

Resources:

Peer Recovery Support Program Staff including:
- Peer Support Specialist/Program Coordinator
- Peer Mentor
- Clinical Supervisor

Umbrella agency which includes:
- Agency Executive Director
- Clinical Director
- IT staff
- Program staff (6)

Funding - SAMHSA
Office space
Community resources / partnering agencies
Volunteers

Program Activities:

Provide recovery-oriented support via 1-on-1 peer mentoring and peer-led support groups
Community outreach via street outreach and community coalition meetings
Peer mentors receive job-related training and clinical supervision
Refer participants to supportive services including housing assistance, healthcare, to support SUD recovery

Outputs:

# of peers trained/working
# of participants connected to supportive services
40% of participants served will represent priority population (see goal statement)

Threats:
- 100% turnover of peer support staff
- Inconsistent data entry

Short Term:

Hire 2-3 peer mentors and 1 peer recovery coach

Intermediate Term:

Peer mentors maintain fidelity to the peer-led model program
Participants are better connected to supportive services (housing, healthcare) to aid SUD recovery
Positive rate of change with the following national outcome measures:
- Abstinence
- Stability in housing
- Employment & Educational status
- Crime and criminal justice status
- Health/Behavior/Social consequences

Long Term:

Participants engaged in ongoing peer support experience increased feelings of hopefulness and greater connectedness to social supports to aid recovery