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“And the next day, you are in charge”: policy recommendations stemming from a qualitative investigation into the professional development of early career peer support specialists in Kentucky.

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“AND THE NEXT DAY, YOU ARE IN CHARGE”: POLICY RECOMMENDATIONS STEMMING FROM A QUALITATIVE INVESTIGATION INTO THE PROFESSIONAL DEVELOPMENT OF EARLY CAREER PEER SUPPORT SPECIALISTS IN KENTUCKY

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DEDICATION

I dedicate this dissertation to my cousins—Joey, Charles, and Cole.

You left this earth far too soon.

ACKNOWLEDGEMENTS

Throughout my journey, special people in my life have helped and encouraged me. Thank you to my husband Steve and my son Connor—Your love and ongoing support made it possible to realize my dream. I want to thank my parents for passing on their love of education. When I said I was going back to school after 20 years, they were just as excited as I was about the opportunity. Thank you to the peer support specialists and key stakeholders for sharing your experiences and expertise.

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ABSTRACT

"AND THE NEXT DAY, YOU ARE IN CHARGE": POLICY RECOMMENDATIONS STEMMING FROM A QUALITATIVE INVESTIGATION INTO THE PROFESSIONAL DEVELOPMENT OF EARLY CAREER PEER SUPPORT SPECIALISTS IN KENTUCKY

Diane M. Zero

July 21, 2021

Over the last twenty years, the peer support segment of the behavioral health workforce has grown rapidly. However, few researchers have studied the effects on individuals from transitioning into the role. Likewise, there is limited research examining the professional development process of early career peer support specialists. To begin to fill these gaps in the literature, I conducted a qualitative research study examining workforce development experiences of peer support specialists in Kentucky. This dissertation reports on its findings and includes a policy paper with recommendations for improving policy and practice.

Chapter one offers an introduction to the peer support workforce literature and summarizes the dissertation. Chapter two provides a literature review on training and supervision within the behavioral health workforce. Chapter three reports on a qualitative study which explored the social process of transitioning from being a patient in care to becoming a peer support working in the treatment field. Constructivist

grounded theory informed the study design, with its methods applied in conducting and analyzing in-depth interviews with the sample of 23 certified peer support specialists entering the field within the last three years.

Study findings showed during the patient to peer support transition, individuals experienced a significant period of adjustment before accepting their new identity. Soon after joining the behavioral health workforce, participants became consumed by their work to the point their personal recovery was at risk. They saw training and supervision as insufficient in preparing them for the day-to-day realities of the peer support role. After time in the field, they successfully transitioned into their peer support identity. In doing so, they created role boundaries and sought support from outside the workplace to reduce their risk of relapse.

Chapter four reports on the 23 peer support workers' early career training and supervision experiences. It describes how their professional development was affected by these workplace experiences, with findings showing there was a wide range of training and supervision experiences among participants. Organizations lacked standards for best practices in their training and supervision. The content, methods, and time allocated for these activities varied from agency to agency.

Most individuals in the study believed their training and supervision was insufficient, that still had knowledge and skills deficits in one or more areas relevant to their position. Participants employed various strategies in filling these perceived gaps, including consulting with their 12-step sponsor, applying an approach learned in their own treatment, and researching the issue on the internet. They were least likely to bring

up needing more training on a topic during supervision. Chapter five is a policy paper providing the rationale and recommendations for amending existing Kentucky regulations governing its certified peer support workforce. Chapter six contains a summary of research findings and recommendations for future work.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS……iv

ABSTRACT……v

LIST OF FIGURES……ix

CHAPTER ONE: INTRODUCTION……1

CHAPTER TWO: STUDY DESIGN AND METHODS……29

CHAPTER THREE: PATIENT TO PEER SUPPORT TRANSITION……48

CHAPTER FOUR: TRAINING AND SUPERVISION EXPERIENCES……81

CHAPTER FIVE: POLICY RECOMMENDATIONS……116

CHAPTER SIX: DISCUSSION, CONCLUSIONS, AND FUTURE RESEARCH……168

REFERENCES……182

APPENDICES……203

CURRICULUM VITAE……206

LIST OF FIGURES

1. PERCENT WITH AMI AND SMI.....2

2. DECREASE IN HEROIN TESTING.....4

3. INCREASE IN FENTANYL TESTING.....5

4. OVERDOSE DEATHS NATIONALLY.....7

5. SUICIDE DEATHS IN KY.....8

6. INCREASED EMS CALLS.....9

7. OVERDOSE DEATHS IN KY.....10

8. SPECTRUM OF PEER SUPPORT.....13

9. KY FACILITIES OFFERING PEER SUPPORT.....17

10. SENSITIZING CONCEPTS AND APPROACH.....31

11. STUDY DESIGN.....31

12. CONCEPTUAL FRAMEWORK.....32

13. CONSTANT COMPARATIVE METHOD.....41

14. CODING STRATEGIES.....43

15. SAMPLING DIAGRAM.....55

16. SOCIAL PROCESS MODEL.....63

17. SAMPLING DIAGRAM.....89

18. CONCEPTUAL MODEL.....93

19. CATEGORIES……97

20. STRATEGIES TO FILL GAPS……107

21. STUDY DESIGN……118

22. CONCEPTUAL MODEL……171

23. LINKS BETWEEN MANUSCRIPTS……172

24. CORRESPONDENCE WITH ROLE IDENTITY THEORY……177

CHAPTER ONE

INTRODUCTION

Significant Public Health Problems

Mental health and substance use disorders affect the health and well-being of individuals, families, and communities throughout the United States. The two are significant public health problems. The two disorders often co-occur in individuals (National Institute on Drug Abuse [NIDA], 2020). The COVID-19 pandemic and its accompanying social distancing requirements have only added to the severity of both problems.

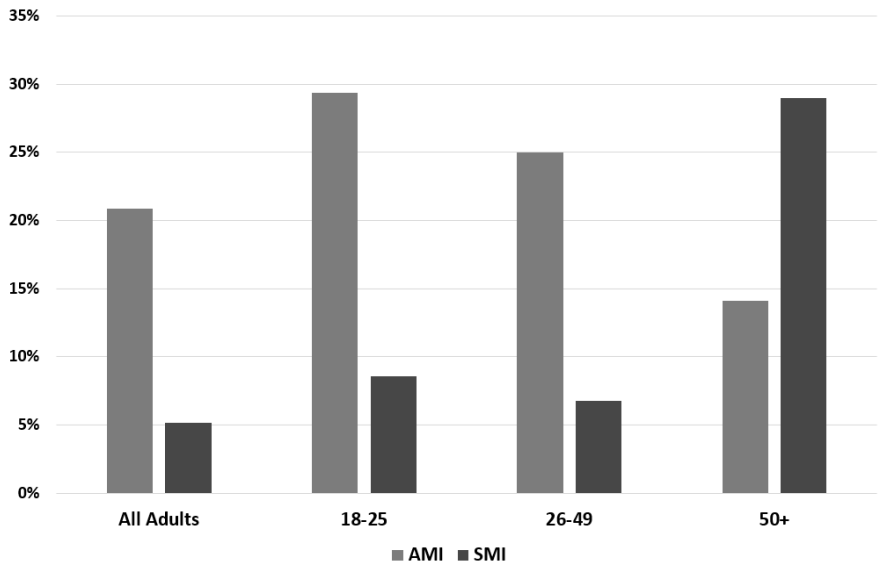
Mental Disorders Nationally

Mental health disorders are among the most common health conditions. In 2019, 20.9% of adults (51.9 million) had any mental illness [AMI] (National Institute of Health [NIH], 2021, January). Prevalence was highest in young adults between 18-25 years of age (29.4%) and 38.9% of these received behavioral health services. In adults 26-49 years of age, prevalence of any AMI was 25.0%, with 45.4% receiving services. The prevalence in adults 50 years and older was 14.1%, with 47.2% receiving services (NIH, 2021, January).

Approximately 14.1 million (5.25%) of all adults 18 years of age and older had severe mental illness [SMI] and 65.5% received treatment. Among the age groups, young adults 18-25 years of age (8.6%) had the highest prevalence of SMI and 56.4% of these individuals received treatment. Among racial groups, adults of two or more races had the highest prevalence of AMI (31.7%) and of SMI (9.3%) (Centers for Disease Control and Prevention [CDC], 2021; NIH, 2021, January).

Figure 1

Percentage of Adults with Any Mental Illness and Severe Mental Illness



Substance Use Disorders Nationally

In 2017, the U. S. Department of Health and Human Services [HHS] declared the country's drug epidemic was a public health emergency (HHS, 2021, February). Over the last two decades, the country has had a 320% increase in the annual number of overdose deaths, from 16,849 in 1999 to 70,630 in 2019 (Ahmad et al., 2021). Accidental overdose has become the leading cause of death in individuals younger than 50 years of

age, with the odds of dying from an overdose (1:96) now higher than dying in a motor vehicle accident (1:103) (Centers for Disease Control & Prevention, 2021, February 11; National Safety Council, 2019). Along with the human cost of the epidemic comes severe economic consequences. The Council of Economic Advisers (2019) reported the estimated total cost of the opioid crisis was $698 billion in 2018. This was 38% higher than in 2015 and accounted for 3.4% of the Gross Domestic Product.

Mental Health in Kentucky

Kentucky has a growing mental health problem among its residents. In 2020, Kentucky had the eighth highest prevalence of any mental illness (Mental Health America, 2021). In 2019, 13.6% of Kentucky middle school students planned for how to kill themselves, compared to 10.5% in 2017. Among high school students in 2019, 14.6% seriously considered suicide compared to 9.6% in 2017 (CDC, 2020).

Between 2008-2010, the state's average percentage of young adults 18 to 25 years of age with severe mental illness was 3.2% and increased to 7.6% between 2017–2019 (SAMHSA, 2020). Among this same group, the percent reporting serious thoughts of suicide increased from 5.9% between 2008-2010 to 10.5% between 2017–2019 (SAMHSA, 2020). For all adults in the state, between 2009 and 2018, suicide rates increased 32%, from 13.6 to 17.9 deaths per 100,000 population (America's Health Rankings, 2021).

Substance Use Disorders in Kentucky

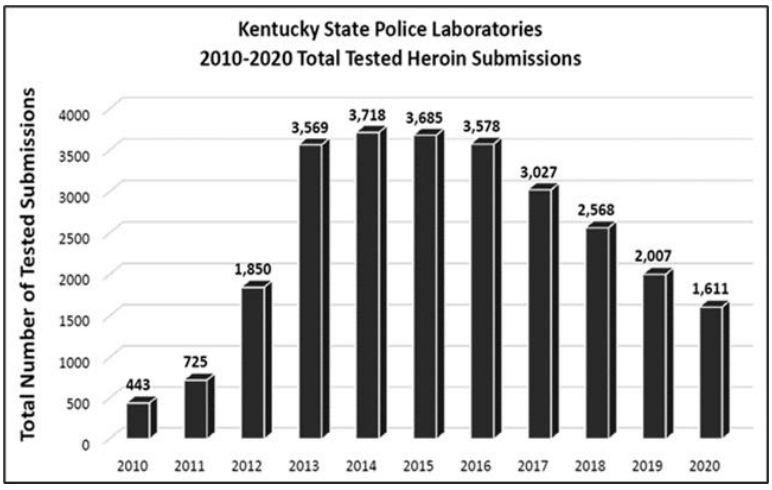
Kentucky is among the states most affected by substance use disorders (Kentucky Office of Drug Control Policy [KODCP] & the Kentucky Agency for Substance

Abuse Policy [KASAP], 2020, March). The age adjusted rate of overdose deaths increased from 4.9 per 100,000 residents in 1999 to 43.7 per 100,000 in 2020 (Ahmad et al., 2021). Nearly one in ten adults in the state reported using illicit substances in 2018 (Kentucky Injury Prevention & Research Center [KIPRC], 2020, July). Early in Kentucky's drug epidemic, prescription opioids and then heroin were the most problematic substances in the state.

Increasingly, the state faces multiple challenges from two substances—fentanyl and methamphetamines. Both have contributed to the increase in overdose deaths in the state. In 2019, 90% of overdose deaths (n=1,178) involved fentanyl and fentanyl analogues, compared to 60% (n=786) in 2018 and 52% (n=763) in 2017 (KODCP, 2020; KODCP, 2019; Akers et al., 2018; KODCP, 2018). Between 2017 and 2019, there was an 44.8% increase in the number of overdose deaths involving methamphetamines (n=357, n=517) (KODCP, 2020; Akers et al., 2018; KODCP, 2018).

Figure 2

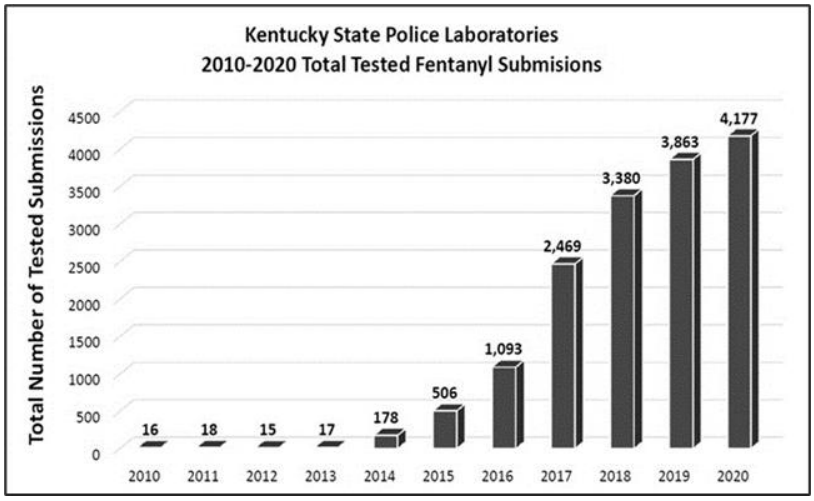
Decrease in Heroin Testing Submissions



Source: Kentucky Office of Drug Control Policy, 2020

Figure 3

Increase in Fentanyl Testing Submissions



Source: Kentucky Office of Drug Control Policy, 2020

Consequences of COVID-19 on Mental Health and Substance Use Disorders

Influence of COVID-19 Pandemic on Mental Health Nationally

The COVID-19 pandemic and its social distancing requirements have worsened existing mental health and substance use disorders. Over half of all women (55%) in the United States reported the COVID-19 pandemic negatively affected their mental health, compared to less than 40% of all men reporting the same (38%). Mental health of young adult women was most affected, with nearly seven in ten women between 18 to 29 years of age (69%) reporting worsened mental health. Among young adult men, 54% reported the same (Kearney et al., 2021, April 14).

From August 2020 to February 2021, the percentage of adults with anxiety or depressive disorder symptoms during the past seven days increased from 36.4% to 41.5%. The percentage of people who reported not receiving needed counseling and/or

therapy for their symptoms increased from 9.2% in August 2020 to 11.7% in February 2021 (Vahratian et al., 2021). Suicidal ideation increased in 2020 with twice as many considering suicide in the previous 30 days (10.7%) than in 2018 (4.3%) (Czeisler et al., 2020).

A natural consequence of individuals' deteriorating mental health has been the sharp increase in service demand. Ridout et al. (2021) found the number of behavioral health related visits increased on average by 7% in the first months of social distancing compared to the same period in 2019. Of these, substance use related visits increased by 51%, anxiety related visits grew by 12%, and psychotic disorder visits were up 6%. Yard et al. (2021) found among adolescents 12–17 years of age in 2020, there was a 31% increase in the proportion of mental health–related emergency department visits compared to 2019.

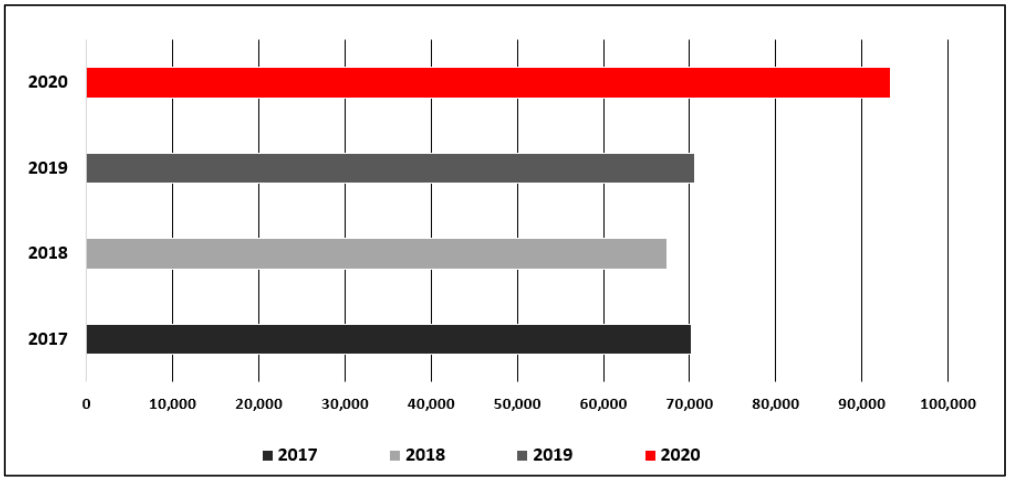
Influence of COVID-19 Pandemic on Substance Use Disorders Nationally

Like mental health, COVID-19's effects on individuals with substance use disorders have been severe. Over the course of the pandemic, we have seen the number of overdose deaths increase. In late 2020, a CDC advisory stated over 81,000 drug overdose deaths occurred in the 12 months ending May 2020 and suggested this increase pointed to an acceleration in overdose deaths since the beginning of the pandemic. At the time, this was the greatest number of overdose deaths ever recorded in a 12-month period (CDC Health Alert Network, 2020, December 17).

Since December of 2020, the situation has only grown more dire. Recent data released by the CDC showed over 90,000 drug overdose deaths occurred in the U.S. in the 12 months ending in September 2020 (Ahmad et al., 2021, May 12). Emphasizing the serious nature of the problem and the ever-increasing need for services, Tom Coderre, Assistant Secretary for Mental Health and Substance Use stated "The spike we've seen in opioid involved deaths during the COVID-19 pandemic requires us to do all we can to make treatment more accessible" (U. S. Department of Health and Human Services, 2021, April 27).

Figure 4

Overdose Deaths Nationally, 2017-2020



Influences of COVID-19 Pandemic on Mental Health in Kentucky

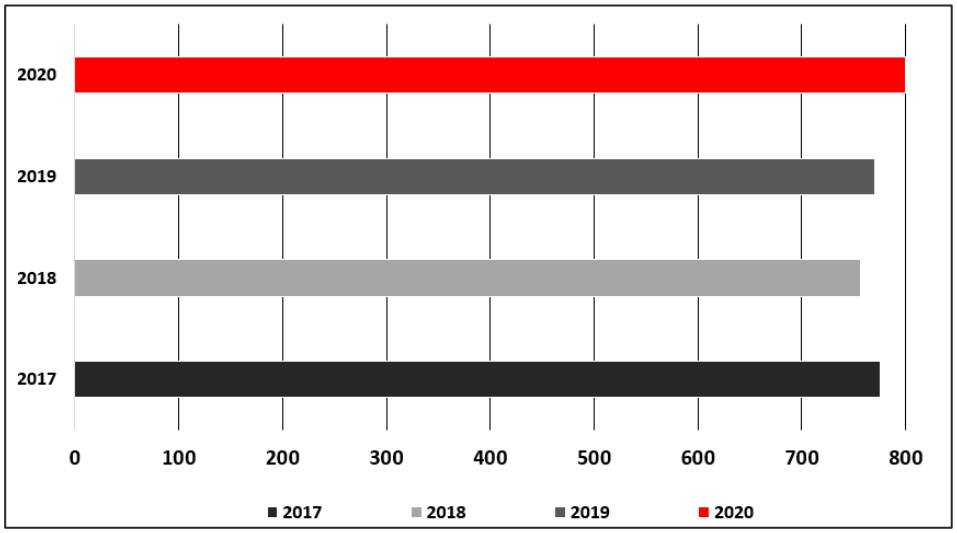
Like the trends seen nationally, the COVID-19 pandemic has negatively affected individuals' mental health and those with substance use disorders in Kentucky. A survey of adults in the Appalachian region of Kentucky found close to 25% of individuals lost income due to the shutdown. About half of those surveyed reported missing and/or

postponing their healthcare appointments (Haynes et al., 2021). On average, 35.2% of Kentucky adults 18 years of age and older reported anxiety and/or depressive disorder symptoms during the pandemic, compared to 30.7% of all adults in the U.S. reporting the same (Kaiser Family Foundation, 2021).

Between February 8 and March 8 of 2021, 74% of Kentucky college students reported an increase in mental and emotional exhaustion during the pandemic. During this same period, 17% of students reported an increase in suicidal thoughts (Prichard Committee, 2021, March). The American Foundation for Suicide Prevention (2021) released preliminary data showing suicide deaths in Kentucky increased from 727 in 2019 to 800 in 2020.

Figure 5

Suicide Deaths in Kentucky, 2017-2020

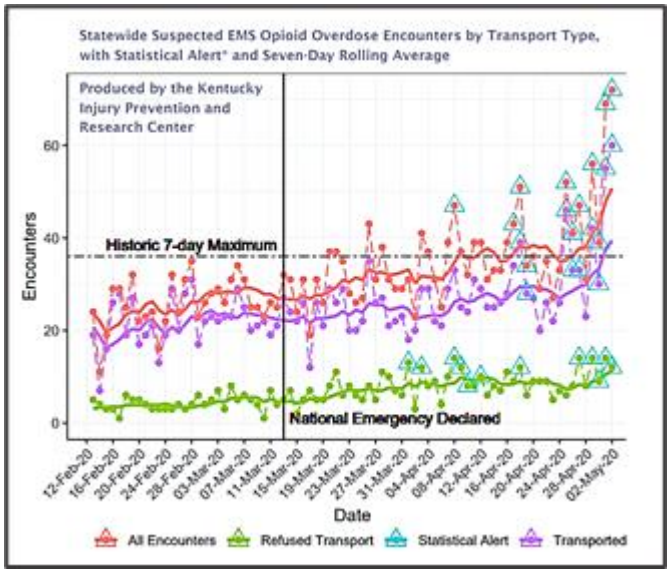


Influences of COVID-19 Pandemic on Substance Use Disorders in Kentucky

As with mental health, the COVID-19 pandemic has only added to the severity of substance use disorders in the state. Early in the pandemic, Kentucky saw the effects from isolation in the number of overdoses reported. The Kentucky Injury Prevention and Research Center (2020, July) reported significant spikes in the number of emergency medical service responses for suspected overdoses were first measured March 26, 2020, less than two weeks after the onset of social distancing.

Figure 6

Increases in EMS Calls



Source: Kentucky Injury Prevention and Research Center, 2020, July

18 Months Into the Pandemic

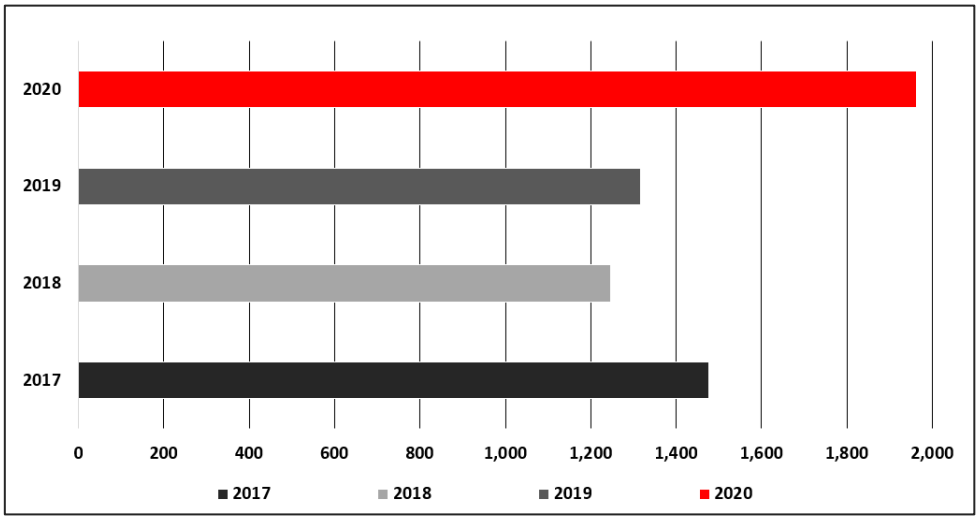
Eighteen months into the pandemic, we have a more complete picture of the COVID-19 pandemic's devastating effects on individuals with substance use disorders in the state. Provisional data estimates for Kentucky showed 1,964 overdose deaths

occurred in 2020, an increase of 50% from the number in 2019 (Steel & Liford, 2021, April 29). The Kentucky Office of Drug Control Policy (2021) reported Jefferson County was the county with the greatest number of overdose deaths. In 2020, the county had 512 overdose deaths, an increase of 60.5% compared to the 319 deaths in 2019.

State officials reported finding several drugs were linked with an increased number of overdose deaths in 2020. Authorities detected methamphetamines in 801 deaths, a 55% increase compared to 517 such deaths in 2019. They detected morphine in 504 deaths compared to 397 in 2019, a 27% increase (Kentucky Office of Drug Control Policy, 2021). The COVID-19 pandemic makes it more critical than ever Kentucky ensures its behavioral health workforce has the skills needed to supply quality mental health and substance use disorder services.

Figure 7

Overdose Deaths in Kentucky, 2017-2020



Shifting to a Recovery-Oriented Treatment Continuum of Care

Historically, the behavioral health field offered treatment services through an acute model of care. Within this model, providers expected the client to complete treatment within 28-days (Vogel, 2018). At the point of discharge, providers considered their client as in recovery. Providers expected individuals with substance use disorders to abstain from using the problem drug for the rest of their lives (Davidson & White, 2007). For individuals with mental health disorders, the reverse was true—Providers expected them to continue taking medication throughout their life.

However, research has consistently shown acute care does not meet the needs of all individuals with mental health and/or substance use disorders. Likewise, no single service or treatment can be equally effective for every person (Kelly & White, 2010). Over time, the field has shifted from the 28-day acute treatment model to offering a more public health focused, recovery-oriented continuum of accessible prevention, treatment, and support services (Volkow et al., 2017; Volkow & Koob, 2015).

Within this new system of care, it is expected each person receives an individualized and tailored range of evidence-based services offered at the level of care best meeting their wants and needs (Kelly & White, 2010). Under this chronic disease model of care, advocates and leaders have conceptualized recovery as a personal process of improved physical and behavioral health. The goal is for individuals' to realize an improved overall social well-being (Kelly & Hoeppner, 2015). In shifting to a recovery-oriented system of care the behavioral health field has, and will continue to, turn to the

peer support segment of the behavioral health workforce to meet the increased demand for treatment.

Peer Support Workforce Nationally

It is difficult to pinpoint the exact number of peer support specialists working in the United States. The Bureau of Labor Statistics does not collect data on peer support workers specifically. Instead, it includes the role within the community health worker category. In May 2016, there were 51,900 individuals employed as community health workers. Their median salary was $37,330 (Chen, 2017, October).

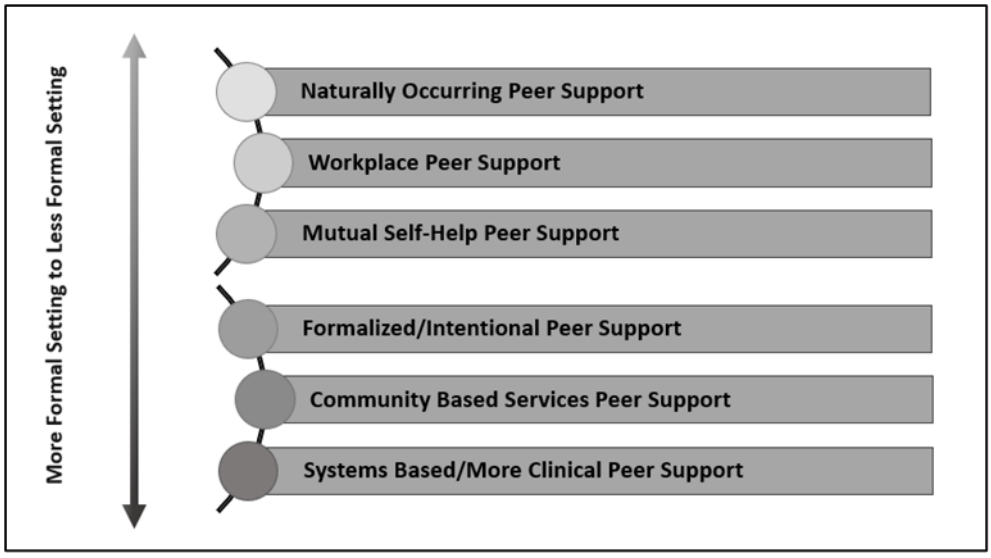
Peer support can provide individuals with acceptance, shared understanding, emotional support, learning opportunities, and can connect individuals with needed resources helpful in maintaining recovery (Mead et al., 2001). At the heart of peer support are four core functions, these include:

1. Assistance with daily management
2. Social/emotional support
3. Linkage to clinical care/community resources
4. Ongoing opportunities for support

There is a range of peer support from informal/naturally occurring to more formal/structured forms when provided in clinical care (Boothroyd & Fisher, 2010; Solomon, 2004) (See Figure 8).

Figure 8

Spectrum of Peer Support Services



Role of Peer Support

Within this transformed system of mental health and substance use disorder treatment, peer support services are at the heart of this person-centered care. In behavioral health treatment, the intent of these services is to complement clinical services—It should not replace them. Over time, the field has recognized peer support services as a specialized resource beneficial in mental health and/or substance use disorder treatment (White & Evans, 2014).

Peer support is unique, it is not a form of mutual self-help. Through experiencing their own unique path to recovery, advocates view peer support specialists as 'experientially credentialed', capable of sharing in a positive manner their personal mental health and/or substance use disorder journey with others working towards similar goals (White, 2007; Davidson, 1999). 'Peerness', a mutuality of shared lived

experience occurs only in peer support. It offers individuals with a type of understanding and acceptance too often absent in more traditional provider-patient relationships (Mead & McNeil, 2006; Solomon, 2004).

Peer support services can be utilized in care for individuals with chronic diseases such as diabetes and high blood pressure, in promoting breastfeeding, and in supported employment (Repper & Walker, 2021). However, most peer support specialists work in the behavioral health field. Though the exact number is unknown, Videka et al. (2019) estimated about 30,000 peer support specialists in the United States were employed in mental health and/or substance use disorder treatment settings such as drug/mental health courts, federally qualified health centers, behavioral health outpatient, peer run organizations, recovery residences, hospitals, in long-term residential care, and in the community.

Depending on the practice setting, titles for the peer support role may vary and includes peer mentors, recovery specialists, consumer advocates, consumer partners, peer support specialists, consumer-providers, recovery coaches, and peer advocates. In this dissertation, I will use the title of peer support specialist. The focus of my work is on Kentucky certified peer support specialists working in more clinical settings such as residential treatment, intensive outpatient, and in primary care.

Role of Federal and State Government Support

In 2001, Georgia became the first state to implement peer support as a billable service under the Medicaid Rehabilitation Option (Landers & Zhou, 2014). In 2007, the Centers for Medicare and Medicaid Services [CMS] issued policy guidance which allowed

inclusion of peer support services as one element in a state's comprehensive mental health and substance use service delivery system under Medicaid (Smith, 2007).

In this document, CMS identified peer support as "…An evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders" (Smith, 2007, p. 1). CMS guidance in the document specified peer support services must be, "…coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals" (Smith, 2007, p. 2). The department outlined other Medicaid reimbursement requirements for peer support workers, which included: (a) certification, (b) sufficient training to deliver services, including continuing education opportunities, (c) demonstration of peer support core competencies, and (d) ongoing supervision provided by qualified mental health professionals (Smith, 2007, p. 2-3).

Since CMS released the 2007 guidance, peer support services have rapidly expanded in the United States (Penney, 2018; Watts & Higgins, 2017). Medicaid, the Patient Protection and Affordable Care Act [ACA], and state general revenue support have offered states greater flexibility in non-clinical service reimbursement (United States Government Accountability Office [GAO], 2020 August; Mechanic, 2012). Various administrations have promoted its use, including Presidents Biden, Obama, and Bush (White House Briefing, 2021, April 1; White House Office of the Press Secretary, 2012, August 31; New Freedom Commission on Mental Health, 2003). Federal and state government support, along with the shortage of behavioral health providers have led to 50 states and the District of Columbia developing the certification needed for service

reimbursement. Peer support services are now the most covered recovery support benefit for Medicaid recipients with mental health and substance use disorders (GAO, 2020).

Peer Support in Kentucky

In 2006, Kentucky began training individuals as adult peer supports and authorized their services as Medicaid billable in 2014. The ability to bill Medicaid and legislation such as the 2010 Patient Protection and Affordable Care Act [ACA] made expanding peer support services more appealing to behavioral health organizations. Kentucky's implementation of the ACA resulted in one of the largest drops in a state's uninsured rate nationally (Garrett & Gangopadhyaya, 2016, December). Between 2010 and 2019, the uninsured percentage of the population decreased 66%, from 16.1% to 5.5% (America's Health Rankings, 2020).

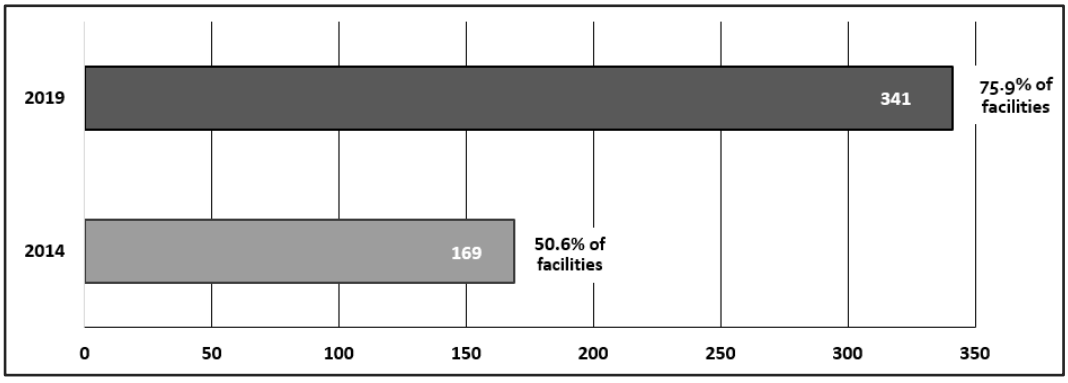
After expansion implementation, the number of individuals in the state receiving substance use disorder treatment services dramatically increased. Between the first quarter of 2014 and the second quarter of 2016, these services grew by over 700% for individuals newly insured under Medicaid expansion, from about 1,500 to over 11,000 (SHADAC & the Foundation for a Health Kentucky [FHK], 2016, December 28). For non-elderly individuals insured under traditional Medicaid, service use increased over 300%, going from less 1,300 to over 4,000 services delivered to this population (SHADAC & FHK, 2016, December 28).

As the ACA increased demand for services, the number of treatment facilities in the state grew. In Kentucky, the number of treatment facilities went from 347 in 2014 to 418 in 2018, an increase of 20.46%. Nationally during this same period, the number of facilities grew from 14,152 in 2014 to 14,809 in 2018, an increase of 4.6%. Kentucky accounted for 10.8% of all new facilities opened in the country during these six years (SAMHSA, 2019; SAMHSA, 2014).

Since 2014, acceptance of Medicaid in substance use disorders treatment has steadily increased from 170 facilities (49.0%) to 341 facilities accepting Medicaid in 2019 (75.9%) (SAMHSA, 2020; SAMHSA, 2014). The number of agencies employing peer supports/mentors in treatment settings has grown, from 169 facilities (50.6%) in 2014 to 341 facilities (75.9%) in 2019 (SAMHSA, 2020; SAMHSA, 2014). In 2019, SAMHSA first reported the number of facilities employing recovery coaches, with 87 facilities (19.4%) offering their services (SAMHSA, 2020). Since 2017, more facilities have added self-help groups like AA, NA, and SMART Recovery, from 115 facilities (32.0%) to 201 (44.8%) in 2019 (SAMHSA, 2020; SAMHSA, 2018; SAMHSA, 2017; Chapman et al., 2015).

Figure 9

Kentucky Treatment Facilities Offering Peer Support, 2014 & 2019



Additional Legislation and Programs Motivating Use of Peer Support

In the state, there were other pieces of legislation and programs serving as additional motivation for agencies to offer peer support services. In 2006, the first Recovery Kentucky center broke ground, its goal to help individuals recover from substance use disorders. Abstinence only, peer driven, long-term single sex residential programs like the Healing Place in Louisville and the Hope Center in Lexington serve as models for the 14 centers.

These centers offer abstinence-based housing and recovery services for up to 24 months to 2,000 individuals at a time. Recovery Kentucky centers are now in the counties of Boone, Carter, Christian, Daviess, Fayette, Harlan, Henderson, Jefferson, Kenton, Knott, Madison, McCracken, Pulaski, Rowan, Taylor, and Warren (Kentucky Housing Corporation, 2021). Medicaid is the primary payor for clients in these centers.

Recovery Kentucky is a partnership between the Department for Local Government (DLG), the Department of Corrections, and the Kentucky Housing Corporation. Funding includes an annual allocation of $2.5 million in low-income housing tax credits, $3 million from the Community Development Block Grant program, and $5 million from the Department of Corrections. Additional funding for program was obtained in the 2020 allocation from the Office of Community Planning and Development [OCPD] Pilot Recovery Housing program. Kentucky received $1.116 million, the fifth highest funding allocation in the country and 4.56% of the total amount granted (U. S. OCPD, 2020, November 25).

Since 2017, six hospital systems in the state created Bridge Clinic programs. The overall goal of these programs is to offer quick access to treatment for individuals experiencing an overdose and/or opioid-related complication. Within the hospital, onsite services provided include access to medication assisted treatment in the emergency department, peer support and/or care coordination (Kentucky Health News, 2017, December 18).

There is another program in the works which could significantly increase demand for peer support services. In 2020, the state submitted to Medicaid its Continuity of Care for Incarcerated Members waiver. CMS approval of this waiver will pave the way for Kentucky to be one of the first states to provide substance use disorder treatment and recovery services to Medicaid eligible incarcerated individuals. These services would include peer support, substance use disorders treatment, and care navigation (Kentucky Department of Medicaid Services [KDMS], 2020, September 30).

Lastly, the Kentucky Opioid Response Effort [KORE] Community Reentry Coordination pilot program has the potential to increase demand for peer support services. Its overall goal is identification of all state prisoners with opioid use disorders 180 days before their release. The program funds a new position—In Reach Coordinators, who provide reintegration services including connection with peer support services (KDMS, 2020, September 30; Manz & Mette, 2020).

Importance of Professional Development

As the peer support workforce has grown, the field increased efforts to standardize competencies through certification training. SAMHSA stressed organizations must pay attention to peer support professional development and integrating their services into the behavioral health care system. Agencies should not assume 'experientially credentialed' on its own prepares individuals for their peer support role (Silver & Nemec, 2016; White, 2010).

Moreover, research has shown the importance of workforce development, including training and supervision. Both are key to the professional growth and self-care of peer support specialists (Hoge et al., 2019; Roche & Nicholas, 2019; Silver, & Nemec, 2016; Simpson et al., 2014). Pratt and Lamson (2012) found supervision served as an effective tool in helping individuals circumnavigate new knowledge and increase familiarity in new situations within their role. Likewise, it is central in providers learning to work together to offer collaborative and integrated care. Carroll (2010) reported training and supervision must paired with one another to be effective within an ongoing process of worker improvement.

To continue growing this workforce, peer support specialists must receive high-quality, ongoing educational opportunities and supervision (Nayar et al., 2017; Ahmed et al., 2015). Nevertheless, the behavioral health field has struggled in shifting practice and policy to incorporate peer support services, including role confusion and inconsistent adherence to training and supervision standards (Kent, 2019; Westat, 2015). Furthermore, co-workers and supervisors have stigmatized individuals working in

the role. Clinical staff and organizational leaders have misunderstood and undervalued their contributions, even though they are the fastest growing segment of the behavioral health workforce. (Jones et al., 2020; Vandewalle et al., 2018; Holley et al., 2015; Scott et al., 2011).

In response, the government and national organizations have focused their attention and funding on the issue over the past five years. They have worked to first understand peer support workforce needs and then to advance their professional development. Mental Health America [MHA] and NAADAC, the Association for Addiction Professionals, have proposed national standards for peer support certification. At the federal level, the 21st Century Cures Act required the Government Accountability Office [GAO] to study leading practices in state peer support certification (GAO, 2018, November). GAO reported to congressional representatives leading practices in this certification included: (a) minimum of 40 hours in certification training, (b) incorporating physical health and wellness into training and/or continuing education, (c) requiring training content to be specific to the peer support role, and (d) organizational training provided by the state to prepare them to effectively employ peers (GAO, 2018, November).

Two priorities in SAMHSA's 2019-2023 strategic plan are improved peer support service integration into the continuum of care and the sustainability of this workforce (2020, December 16). In 2021, the SAMHSA Peer Recovery Center of Excellence named workforce development as one of its four core focus areas to enhance peer support

professionalization. The center serves all states and tribal communities in the United States, offering no cost training and technical assistance.

Despite these efforts, the behavioral health field has failed to agree on a unifying framework in certification standards. At the same time, it has not accepted a national set of standards for onboarding and supervision to continue peer support development once in the field (McBain et al., 2021). Consequently, state agencies have generated their own interpretation of best practices. Legislators have chosen which to apply when creating their state's peer support regulations.

Problem Statement

Within the behavioral health workforce, front line staff like peer support specialists typically spend the most time with clients. Through working closely with clients while in care and to sustain recovery once treatment has been completed, peer support offers opportunities to improve treatment outcomes. Individuals working in the role can help alleviate the strain on the system coming from the behavioral health provider crisis (Walker et al., 2021).

Nevertheless, the training and supervision of peer support workers remains a piecemeal process, with many individuals never receiving the support needed to succeed in their peer support role. Overall, the field devotes little time and resources on their professional development. This neglect by agencies can have far reaching consequences on the peer support workforce and on their clients. Workforce development activities such as training and supervision are key components in ensuring "…There is a workforce of appropriate size, composition, and competency to address

mental health and substance use related needs in a specific geographic area or the nation at large" (SAMHSA, 2013). Without these activities, both the workforce and clients may suffer.

Kentucky's successful implementation of the Affordable Care Act allowed many individuals to access care and offered additional sources of reimbursement for peer support. Since implementation, the number of agencies offering peer support in treatment settings has increased from 169 facilities in 2014 (50.6%) to 341 in 2019 (75.9%). However, the state offers minimal oversight during the certification process and in ensuring the professional development of peer support workers once in the field. Likewise, there has been little effort by researchers to examine workforce development activities, including how agencies train and supervise Kentucky's peer support workforce. Given we know organizations too often overlook workforce development with front line workers like peer support specialists, these issues are especially concerning.

All we can say with any confidence when it comes to Kentucky's peer support workforce is that 28 agencies offered 149 certification trainings and 1,013 individuals passed their certification exam in 2020 (Bogarty, 2021, May 20). We lack information on agencies' use of activities such as onboarding, supervision, and continuing education to grow these workers. We cannot evaluate how each impact peer support professional development nor any effects from these activities on peer support workers' competencies for delivering high-quality services.

Study Purpose

Considering these issues, we need to understand how Kentucky peer support specialists perceive, experience, and respond to the training and supervision provided by their employers. In the behavioral health field, this data is essential in planning future successful workforce development policy and practice (Hoge et al., 2019; Roche & Nicholas, 2019; Hoge et al., 2016). In response to these identified gaps in the research, I conducted a qualitative study focused on understanding Kentucky peer support specialists' experiences of training and supervision and how these affected their professional development.

Approaching the research qualitatively allowed for developing a deeper, more nuanced understanding of a complex issue not easily quantifiable (Creswell & Creswell, 2017). When writing the three manuscripts of my dissertation, I have incorporated study findings from my work. Through my work, I hope to contribute to efforts to improve practices and policies in Kentucky around peer support training and supervision.

Research Aims

The aims of my research were to:

1. Explore the transition from patient to peer support specialist as a social process during individuals' first three years of working in mental health and substance use disorder treatment in Kentucky.
2. Understand and describe effects from early career training and supervision experiences on peer support professional development.

3. Identify actions taken by these peer supports to fill perceived gaps in role related knowledge and skills.

Positioning the Researcher

When reflecting on my position as the researcher, I always return to a specific quote from Malterud (2001), "A researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions" (p. 483-484). This quote reflects the decisions I have made on what and how I research.

My work largely focuses on behavioral health disorders due to my family's long struggle with the disorder, including loss of three cousins. I watched their mothers, fathers, and siblings first try to understand how to help a loved one with the disorder, then later struggle to cope with losing their family member to the disease. Each of my cousins' deaths affected how I see the disorder. I never had a big brother, but my cousin, J., filled that role for me. He would tease me about boys, bring me on roller coasters, and give me advice for when I grew up.

When I was 10 years old, J. died of a heroin overdose at age 17. He was left by his friends in the park across from his home and found the next morning by his father when he went out for the paper. When I was a child, the reason for his death was never explained. I feel never explaining his death reflected the shame and stigmatizing beliefs surrounding substance use disorders and overdose deaths.

Over the years, I heard his death attributed to being sick or having a problem, with this illness and problem never defined. Instead, it was stressed how loved J. was by his classmates, that at the viewing every person he knew at school put their class ring in his casket to be buried with him. Later on, when I put the pieces together on why J. had died I confronted my mother, only to be told I was too young back then to hear the 'truth'.

When his brother P. died twelve years later, I saw one of his sisters' unable to deal with her grief and refused to attend his funeral. She said not attending stemmed from her anger at all he had done to her mother and father over the years, that she could not forgive him. When her nephew C. died fifteen years later at age 17, I saw her try to make sense out of losing yet another loved one, repeatedly referring to the curse on their family. I watched her children struggle to understood losing their cousin. I watched C.'s mother and father overwhelmed with grief and his brother blame himself for his brother's death. I saw this same brother refuse to have children, saying he could not see his child die because he passed on the family curse. Yet again, I watched other family members cast blame and stigmatize the deceased.

Likewise, my professional life in the social services sector influences how I perceive issues and approach my work. Before returning to school, I often saw the impact of substance use disorders on families throughout my career. When first moving here from Washington DC, I worked as the administrator of a residential campus and the youth placed regularly had parents with substance use disorders. I would see their anger and sadness when they questioned why a drug was more important to their mom

or dad than them. Too often, they were placed in our care due to turning to substances themselves to deal with these feelings. While I left that position 20 years ago, it feels like nothing has changed with substance use disorders.

In a later position, I served as Executive Director of a family support and education focused non-profit. As part of this work, the agency hosted bi-monthly educational programs for the parents and children. Over my 10+ plus years there, I worked with numerous grandparents with custody of their grandchildren due to their own child's substance use disorder. One man, a grandfather with custody of two grandchildren would often tell me he would get it right this time around, he learned from failing his own children.

There was one young lady, S., I will never forget. She entered our program at age five and for the first three years, she lived with her grandmother because her mother was in and out of the criminal justice system due to her drug misuse. For the first three years I knew them S. thrived, she did well in school, was always happy to see you, and to participate in program activities.

In the beginning of her fourth year in the program, grandma unexpectedly died. With no other living relatives, she returned to the care of her mother. Within six months, she transformed from that happy, thriving child to one who often missed school and when she did attend an event we hosted, she was often ungroomed and hungry. Soon after this, she simply disappeared from the program. I later learned school called Child Protective Services [CPS] when they did not hear from why S. was out of

school for close to a week. CPS learned mom had left S. alone in the house and went out of town.

During each experience, I often questioned why negative consequences had seemed to grow more severe over the years and wondered why we made no real progress. It seemed when we never learned how to address this problem, both within my family and at the systems level. Through this dissertation, I hope to contribute to efforts to change the status quo existing for far too long.

CHAPTER TWO

STUDY DESIGN AND METHODS

Research Design

Theoretical and Conceptual Framework

When examining a particular phenomenon, applying theory guides the research process. The researcher's use of theory is key in answering study research questions. Theory assists them in describing and explaining findings (Maxwell, 2012). Miles and Huberman (1994) reported the researcher's use of conceptual framework "…Lays out the key factors, constructs, or variables, and presumes relationships among them" (p. 440).

Along with my position as the researcher, the philosophical tenets of Symbolic Interactionism framed my overall approach to this research. These include: (a) individuals act toward things based on the meanings those things have for them, (b) the meaning of things develops through social interaction, and (c) meanings are created through a process of interpretation (Blumer, 1969). Symbolic Interactionism's roots trace back to the work of notable pragmatists and their conceptualizations of process. Influential figures include Mead's notion of an objective reality with interacting perspectives, Pierce's explanatory conceptualization of abduction accounting for new

ideas emerging in critical thinking, and Dewey's description of problem solving as an iterative-circular process (Bryant, 2017).

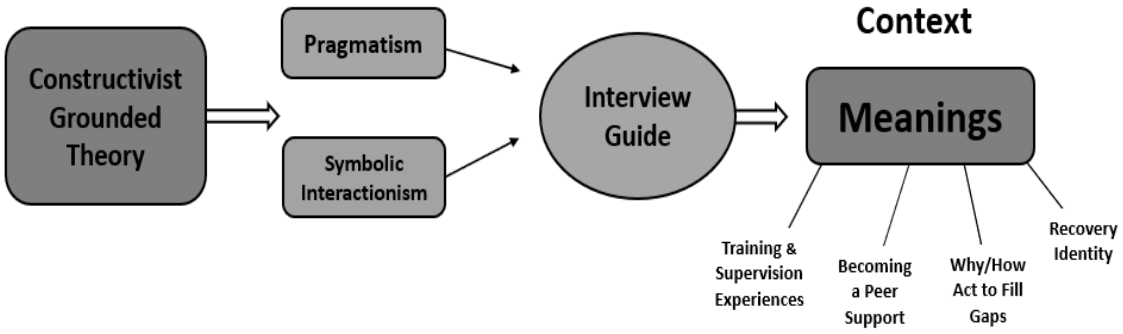
In developing Symbolic Interactionism, Blumer reimagined many constructs from Mead's pragmatic ideas. He acknowledged doing so in his seminal work, Symbolic Interactionism: Perspective and Method (1969). He stated "I rely chiefly on the thought of George Herbert Mead who, above all others, laid the foundations of the symbolic interactionist approach" (p. 1).

In Symbolic Interactionism, Blumer's constructs reflect Mead's conceptualization of the social world as an ever renewing and re-creation of learning through processes rooted in experiences and interactions, and all part of our ongoing production of meaning. These processes are relational and always situated within the context of our social relations. To understand an issue, we must identify the context in which each occurs (Huebner, 2016; da Silva & Vieira, 2011).

According to Symbolic Interactionism, individuals construct personal, subjective, and social meaning in their world through process, and in response to changing perceptions of their environment continually adjust their actions in their social world (Glaser, 1998). Interactions are dynamic and interpretive, essential in how individuals create and change meanings and actions. Because of this, the motivations behind an individual's behavior cannot be understood from a detached vantage point, apart from context (Blumer, 1969). See Figure 10 for a model of these sensitizing concepts and approach to the research.

Figure 10

Sensitizing Concepts and Approach



Study Aims

In my work, I sought to understand and explain:

1. Training and supervision experiences of peer support workers entering the field within the last three years in Kentucky.
2. Participants' meaning making constructed from these workplace experiences.
3. Participant actions taken in response to these experiences.

In addressing the aims of my study, I examined social processes within the context of peer support training and supervision experiences in Kentucky. By framing the study in this manner, I could better understand the nuanced, interconnected layers of a complex issue (Glaser, 1998; Blumer, 1969).

In the interview guide, I explored these ideas around meaning making from experiences through the interviews and member checking. I sought to understand how participants acted in response to their training and supervision experiences. Further, I identified participant actions in response to a perceived gap in role related skills.

Figure 11

Study Design

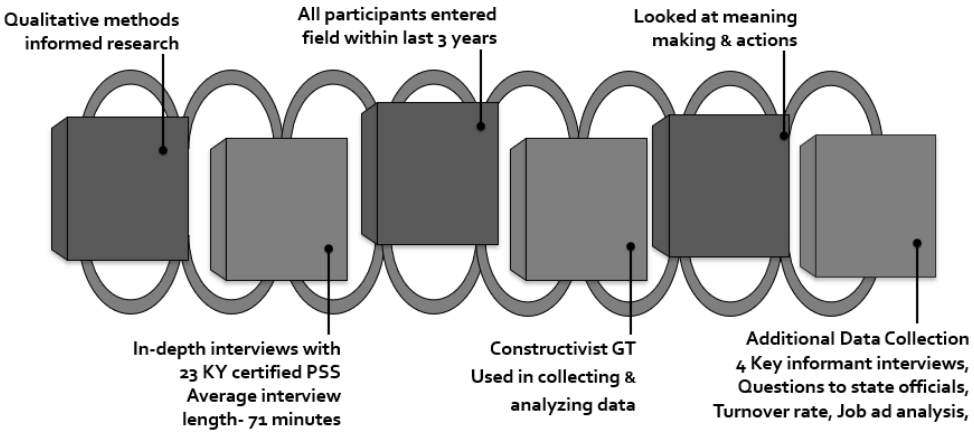
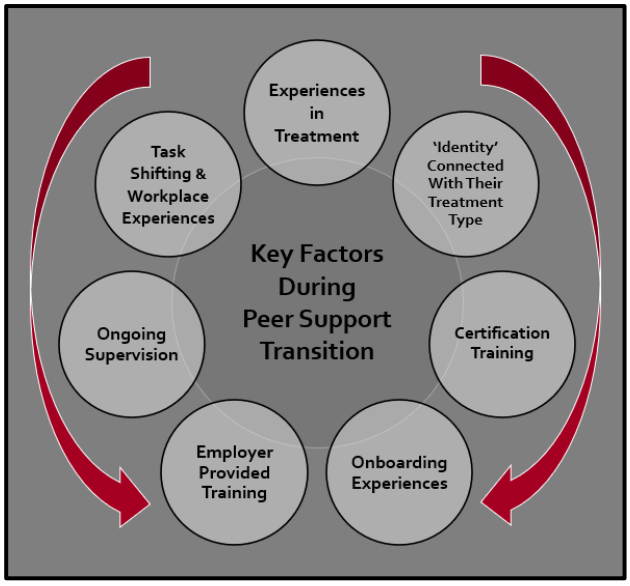


Figure 12

Conceptual Framework



Use of Grounded Theory

In this dissertation, my decision to use Constructivist Grounded Theory [CGT] reflected study aims—To gain insight into the psychosocial process individuals undergo in response to a social interaction. Specifically, I wanted to understand the meanings participants made of their experiences and what actions they took in response to these experiences (Glaser, 1978). The roots of CGT are based in the classic Grounded Theory method developed by Glaser and Strauss. They were two American sociologists from the Chicago School of Sociology. The term, Grounded Theory, refers to the product of inquiry. It is defined as the research produced and the method the researcher used to construct it (Charmaz, 2016).

Glaser and Strauss brought their quantitative and qualitative research backgrounds to their work in Grounded Theory. This resulted in the method having both positivist and constructivist elements to it. Positivist aspects reflect Glaser's training as a survey researcher. This appears in Grounded Theory as the systematic approach to the work and the requirement researchers approach the work as a naïve learner (Charmaz, 2016).

The more constructivist influences in the method work reflects Strauss's earlier work in Chicago School Pragmatism, Symbolic Interactionism, and his prior field research. Starting in 1989, we see a divergence in the underlying beliefs of the two researchers which had surrounded their work until this point. The two men parted ways and from this split, Glaserian and Straussian Grounded Theory approaches emerged (Rieger, 2019).

Grounded Theory's reach extends beyond any one discipline, it is one of the most widely used qualitative methods. Over the last 40 years, researchers in health-related fields such as public health and nursing have applied Grounded Theory in studying numerous topics, including individuals' treatment experiences, health and wellness, agency leadership, recovery, the impact of the ACA on the system of care for behavioral health treatment, and in studying provider mentoring within the workplace (Rieger, 2019). Use of the method has only grown in recent years, with journals becoming more accepting of publishing their qualitative work.

Grounded Theory is a systematic method of conducting research shaping data collection and supplying clear strategies for analysis, with the analytic focus emerging during the research process. Researchers ground any theories developed from their work in the data itself. Any claims they make come from the very voices of participants (Charmaz, 2014). These systematic, yet flexible strategies are a unique feature to Grounded Theory, not found in other qualitative methods. Researchers apply these in examining basic social and social psychological processes as they occur in natural settings (Charmaz, 2016).

When researchers chose to use the Grounded Theory method, their objectives can include: (a) establishing qualitative research's capabilities in generating theory; (b) illustrating and supplying systematic strategies in collecting and analyzing data, (c) advancing the method for examining processes, and (d) making the practice of theorizing accessible to researchers (Charmaz, 2016). Charmaz stated the ultimate

purpose of the method is to allow the researcher to "…Construct a theory that offers an abstract understanding of one or more core concerns in the studied world" (2016, p. 1).

Use of Constructivist Grounded Theory

A former student of Glaser and Strauss, Kathy Charmaz, developed Constructivist Grounded Theory. In 2000, Charmaz proposed a more constructivist stance to Grounded Theory, rooted in social constructionism of the 1970's and 1980's. Through accounting for research construction and researcher/participant subjectivity, Charmaz expanded the method. Constructivist Grounded Theory [CGT] kept ideas and concepts from classic Grounded Theory beneficial in the work of research. She then incorporated a more modernized approach. CGT was more reflective of twenty-first century ontology, epistemology, and methodologies developed after the 1960s. Charmaz (2016) stated by doing so, "…It brought into purview relationships between the viewer and the viewed, fact and value, and the conditions of research and its products" (p. 404).

Charmaz has emphasized this form of "Grounded Theory favors theory construction over description, collective patterns over individual narratives, developing fresh concepts over applying received theory, and theorizing processes over assuming stable structures" (2016, p. 403). In theory construction, the researcher's use of the method is strengthened by two key factors—flexibility and focus. They can adaptively apply specific strategies of Grounded Theory to best fit conditions around their research problem, while concurrently using the approach to sustain focus on theoretical construction (Charmaz, 2016; Charmaz, 2014).

Through applying a Constructivist Grounded Theory lens to my research, I could detect the range of beliefs around training and supervision held by study participants. Though its use, I could understand how individuals framed their professional identity within the context of training and supervision experiences. I could understand the meanings made by participants of their experiences and actions taken in response to these experiences. Approaching the study in this manner best fit with my overall goal of understanding the underlying process of a phenomenon (Creswell, 2007).

Study Design

Recruitment and Sample

After receiving study approval from the University of Louisville's Institutional Review Board in late October of 2020, I initially recruited participants from community behavioral health treatment programs using convenience and snowball sampling. Individuals gave consent before becoming part of the study and received a $20 Amazon gift card as an incentive. Early on, I was intentional in recruiting a diverse sample of providers entering the behavioral health workforce within the last three years (n=8).

Providers interviewed in the initial phase of sampling included a psychiatrist, a counselor, social workers, a harm reduction specialist, and peer support workers. Through taking this approach, early interviews offered me insight into a variety of early career training and supervision experiences for a range of positions within the behavioral health workforce. For example, the interview with a psychiatrist led to my conceptualization of an integrated model of peer support services within the context of a Kentucky behavioral health practice. Through interviewing the counselor and social

workers, I gained understanding into the training and supervision of more clinical providers.

As I explored an emergent lead in meaning making of these experiences by individuals working as peer supports, recruitment narrowed to individuals employed in this role who entered the field within the past three years (n=20). For manuscript one and two, I have included only data collected in the 23 peer support interviews. Use of theoretical sampling in this manner allowed me to further develop research aims and refine developing theoretical concepts (Charmaz, 2014). To deepen my understanding of this complex issue, I collected additional data when writing manuscript three. The next section outlines this phase of data collection.

Paper Three- Additional Data Collection

To develop my recommendations for policy and practice in manuscript three, I used findings from the in-depth interviews with the 23 certified peer support specialists. To further expand my understanding of this complex issue, I interviewed four peer support subject experts and used the data collected to guide my thinking. consented to use of their identifying information in the dissertation. The four interviews were with:

1. Teresa Walker, a psychiatrist and owner of the New Leaf Clinic, in the West End of Louisville.
2. Marcie Timmerman, Executive Director of Mental Health America-Kentucky.
3. Rebecca William, South-East regional representative with the Americans with Disabilities National Network.

4. Christopher Laureano, a certified peer support and Director of the Recovery Education and Learning (REAL) Program of Boston, Massachusetts.

In the first interview, I spoke with Teresa Walker, a psychiatrist working in the West End of Louisville. She has integrated peer support work into her practice, though she does not bill Medicaid. We discussed how she pays the wages and covers program costs. She has paid these out of her profits from her other billing. I used our discussion to conceptualize an evidence-based model for integrating and sustaining peer support work within a behavioral health agency.

For the second interview, I spoke with the Executive Director of Mental Health America-Kentucky. She provided offered historical background on the development of the peer support workforce in Kentucky and thinking behind the state's limited oversight over these workers. Our conversation also guided wording in the questions asked Kentucky state officials. In the third interview, we discussed key factors within in the Americans with Disabilities Act protecting employment rights of individuals in recovery. We discussed wording differences in the adult, family, youth peer support regulations.

In our interview, I asked about the language used by the state in regulations. As an example, in adult and family peer support certification regulations, the state uses the word [mental health/substance use] disorder. However, they describe this as [mental health/substance use] disability in the youth peer support regulations. Rebecca William confirmed no matter how state regulations are worded, individuals with an impairment which is episodic and/or one in remission are considered to have a disability if it would

substantially limit a major life activity when it is active. For individuals with substance use disorders, this means they have ADA protections only when they are abstinent. For both individuals with mental health and substance use disorders, the ADA expects employers to make reasonable accommodations unless it causes undue hardship.

In the fourth interview, I talked with Christopher Laureano, a certified peer support and the Recovery Education and Learning (REAL) Program Director in Boston Massachusetts. He provided information on the state's work in peer support development, specifically how they work with individuals before they become certified peer support specialists working in mental health treatment settings. Recommendations around implementing a similar program in Kentucky specifically came out of our discussion.

Questions Submitted to State Officials

To clarify regulation development for certified and registered peer support specialists in Kentucky, I submitted questions to:

1. Kevin Winstead, Kentucky Commissioner for the Department of Professional Licensing within the Kentucky Public Protection Cabinet.
2. Cheryl Bogarty, Program Administrator for the Division of Behavioral Health within the Adult Mental Health and Recovery Services Branch.
3. Senator Julie Raque Adams, sole legislator sponsoring a 2020 bill amending peer support registration regulations.

When I needed further clarification on a point, I followed up with Mr. Winstead and Ms. Bogarty. To date, Senator Adams has not responded to my questions, I have sent two follow-up emails asking her to do so.

Data Collection

To best understand an individual's personal meaning making of workplace experiences, the researcher conducted in-depth interviews using an interview guide (See Appendix A). Interviews are useful as the primary data collection method for facilitating free flowing, open dialogue with participants. Researchers' use of the method is appropriate for discussing sensitive issues such as personal recovery from a mental health and/or substance use disorder (Creswell & Poth, 2017).

In developing the initial interview guide, I was guided by the tenants of Symbolic Interactionism and Pragmatism. Questions focused on understanding participant experiences, meaning making, and their actions taken in response to these experiences. As well, workforce development research produced by subject experts and the work of organizations such as SAMHSA, the Addiction Technology Transfer Center [ATTC], from Mental Health America, and NAADAC, the Association for Addiction Professionals informed its design. After conducting early interviews, I assessed the guide for question relevance and comprehensibility, then made revisions when appropriate.

Due to social distancing restrictions from the COVID-19 pandemic, I conducted interviews online through Microsoft Teams and by telephone when participants lived in an area of Kentucky with low internet bandwidth. With the consent of participants, I recorded their interview. Study interviews ranged from 45 to 95 minutes in length, with

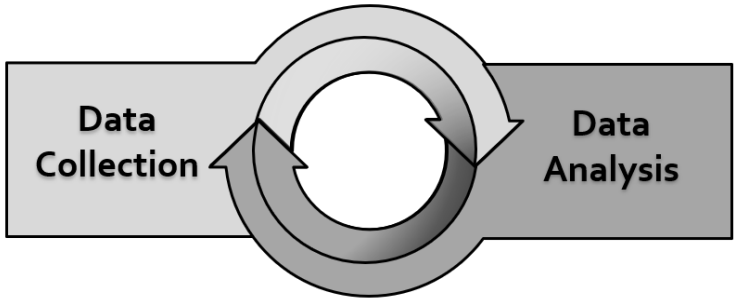
an average interview time of 71 minutes. After the interviews, I transcribed these recordings verbatim, with participants using pseudonyms to protect privacy and confidentiality. To build awareness of personal bias, I engaged in field notes and reflexive memo writing. Additionally, I used both to reflect on ideas to explore in coming interviews and to conceptualize theoretical ideas developed while interacting with study participants.

Analytic Strategies

I used the constant comparative method embedded within constructivist Grounded Theory in analyzing study data. It required me to continually move between data collection and analysis (Glaser, 1969). In this study, I detected gaps in knowledge through continually collecting, studying, and comparing data and explored these in later interviews. In constructivist Grounded Theory, coding is the needed link between data collection and the explanation of this data (Bryant & Charmaz, 2007). It gives the researcher opportunity to contextualize what emerges out of the data, then connect it to participant action and meaning making (Charmaz, 2014).

Figure 13

Constant Comparative Method



Adapted from Glaser, 1969

Coding and Saturation

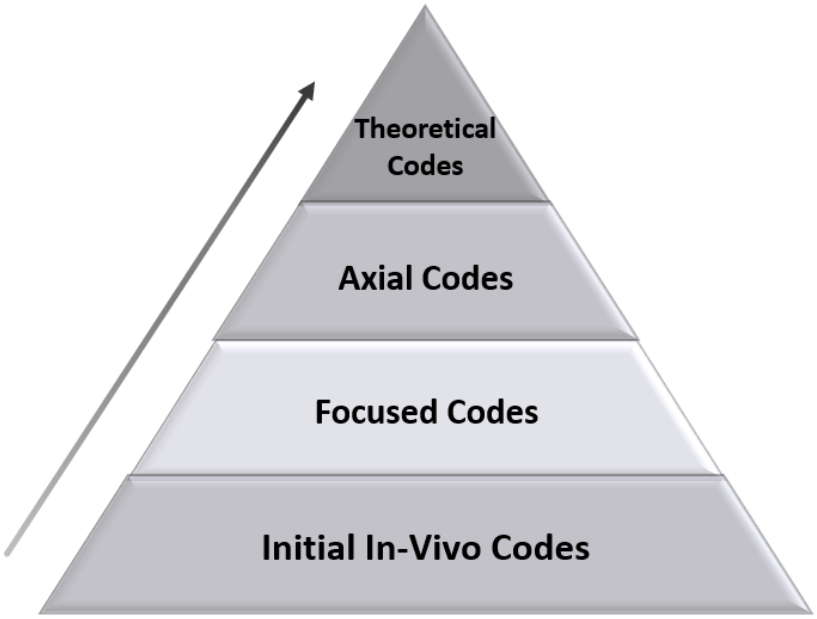
Through applying gerunds as codes (—ing words) and through separating data into broader concepts, I conducted initial, line by line open coding. I applied in-vivo coding to dissect, scrutinize, compare, conceptualize, and categorize these data. Initial coding focused on the individual's language, processes, actions, and meanings (Corbin & Strauss, 1990). To develop focused codes, I moved from data to data and looked for what appeared frequent and what seemed significant (Charmaz, 2014).

To conceptualize how substantive codes interrelated to one another within the research's central aims, I applied theoretical coding. Glaser and Strauss (1967) defined this sampling as, "…The process of data collection for generating theory whereby the analyst jointly collects, codes, and analyses his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges" (p. 45). See Figure 14 for a model of these coding strategies.

I applied guidelines issued by Glaser (1978) and Morse (1995) to determine the point of theoretical saturation including: (a) prolonged engagement in the field, (b) thick, rich description, (c) inter-rater reliability, (d) framework development, (e) peer review, (f) clarifying researcher bias, (g) member checking, and (h) triangulation. MAXQDA, a qualitative data management program was used in organizing the coding process. After uploading descriptive demographic information, I analyzed the data for frequency distributions (See Appendix B for the Demographic Characteristics Survey).

Figure 14

Coding Strategies



Adapted from Corbin & Strauss, 1990

Enhancing Study Rigor

Researchers have long debated the precise indicators and exact methods of determining quality in qualitative research. However, each agrees there is, and will continue to be, need for qualitative researchers to demonstrate their work is credible and trustworthy (Tracy, 2010; Creswell & Miller, 2000; Maxwell, 1996; Lincoln & Guba, 1985). In this study, I utilized multiple strategies to ensure the quality of my work.

To increase study rigor, I completed an interrater reliability assessment with an individual skilled in qualitative methods. This person was neither involved in data collection nor in the preliminary stages of data analyses. This assessment produced a Cohen's Kappa test statistic of .95, which indicated excellent agreement (Cohen, 1960).

Member checking with participants around emergent concepts and themes occurred throughout data collection and analysis. I employed other analytic tools during the study to clarify issues and to develop the social process model framework. This work included situational analyses through positional/situational mapping and memo writing (Clarke et al., 2017).

To ensure my work was high quality, I followed the Big Tent criteria as developed by Tracy (2010). Dimensions of this criteria include: (a) being a worthy topic, (b) rich rigor, (c) sincerity, (d) credibility, (e) resonance, (f) making significant contribution, (g) ethical research, and (h) meaningful coherence (Tracy, 2010). Tracy designed the criteria to "…Provide a parsimonious pedagogical tool, promote respect from power keepers who often misunderstand and misevaluate qualitative work, develop a platform from which qualitative scholars can join together in unified voice when desired, and encourage dialogue and learning" (p. 839).

Throughout my research, I used these guidelines to increase the rigor, credibility, and trustworthiness of my work. The rapid expansion of the peer support workforce both nationally and in Kentucky and a lack of national standards for training and supervision allowed me to identify my topic as worthy and significant. Through my research, I came to recognize a gap in the literature. Once I did so, I worked to increase our understanding of peer support professional development activities in Kentucky. I identified the implications of Kentucky taking a more hands off approach to the oversight of these workers. In manuscript three of the dissertation, I used study findings to develop practice and policy recommendations.

Using these guidelines, I can demonstrate my work was ethical throughout the study. Before beginning data collection, I received Institutional Review Board approval (procedural ethics). Throughout the study, I took responsibility for my actions. My responsiveness to participants' needs and concerns demonstrated relational ethics. As an example, several participants were the only peer support at their organization and/or were the only peer support working in a county who was not white. It would have been easy for agency leaders to recognize these individuals had I listed each county where participants worked. To ensure their identities were protected, I used the Centers for Disease Control and Prevention NCHS Urban-Rural Classification Scheme for Counties to identify the different parts of the state where study participants worked, rather than supplying county names where study participants were employed.

I met the Big Tent criteria required for ensuring an overall process of research quality, including having significant time in the field and in data collection/analyses (rich rigor). Rather than assuming my interpretations of the data were correct, I used member checking as an opportunity to explore emerging concepts and ideas with participants. Throughout the study, I worked to ensure self-reflexivity and transparency (sincerity). Study findings are based in the very voices of participants. Throughout my study reporting, I provided thick description supported by concrete detail to show rather than tell (credibility).

By achieving its stated purpose, my study met the criteria for meaningful coherence (Tracy, 2010). To gather and analyze data in more than one way at more than one time, I applied a triangulation of sources (Jonsen & Jehn, 2009; Creswell & Miller,

2000). These sources included field notes, interviews, memoing, and a member checking interview/focus group. Later in the data analysis process, I used the MAXQDA qualitative software to organize coding and in the Cohen's Kappa interrater reliability assessments for manuscript one and two. This work resulted in a test statistic of .95 and indicated excellent agreement (Cohen, 1960).

Throughout the study, I gathered the thick and rich description needed in developing theory. In doing so, I transcribed each interview verbatim from the recordings. Additionally, I wrote detailed, extensive observational field notes immediately after each interview and engaged in memoing. The practice of writing field notes includes detailing observations about what was noteworthy, was interesting, and/or the most informative (Emerson et al., 2011; Wolfinger, 2002).

Memo writing can take place at any point between coding and writing the first draft of the manuscript (Charmaz, 2016). In early memos, I wrote about code development, worked through remaining questions around analysis/method, and reported on data fragment comparisons. Later, my memos became more analytic when I took codes apart to closely question the data (Charmaz & Thornberg, 2020).

From my research, I developed three manuscripts for this dissertation. *'Developing a Professional Identity: A Grounded Theory Study of the Transformation from a Patient to a Peer Support Working in Behavioral Health Treatment'* is manuscript one. Manuscript two is *'A Qualitative Investigation of Peer Support Training and Supervision Experiences in the Behavioral Health Field'*. Manuscript three is *'Policy Recommendations Stemming from a Qualitative Investigation into the Workforce*

Development Experiences of Early Career Certified Peer Support Specialists'. Each manuscript is a chapter in the dissertation.

CHAPTER THREE

TRANSITION FROM PATIENT TO PEER SUPPORT

Introduction

Over the last 20 years, the behavioral health field has transformed how it conceptualizes and delivers care for mental health and substance use disorders. It has discarded the older 28-day acute model of treatment for an integrated, individualized continuum of care which reflects the complex, chronic nature of the disorders (Substance Abuse & Mental Health Services Administration [SAMHSA], 2018; White et al., 2012). At the heart of this person-centered approach is a holistic view of recovery as a self-directed process of change with the goal to improve a person's overall wellbeing, so they may realize their full potential (Piat et al., 2016; Davidson et al., 2007; New Freedom Commission, 2003).

Peer support is a key element in the behavioral health field moving to a person centered and recovery-oriented model of care (SAMHSA, 2020; White, 2007). SAMHSA (2017) defined peer support as "…a person who uses his or her lived experience of recovery from mental illness and/or addiction plus skills learned in formal training, to deliver services in behavioral health settings to promote mind-body recovery and resilience" (n. p.).

In the United States, approximately 30,000 certified peer supports are members of the behavioral health workforce. Their services expand treatment outside the clinical setting and into the everyday world of persons wanting a successful, sustained recovery (SAMHSA, 2020). Titles for the peer support role vary depending on the practice setting, these include peer recovery support specialists, peer support specialists, consumer-provider, peer recovery coaches, and peer advocates.

Medicaid, the Patient Protection and Affordable Care Act, and general revenue support offered states greater flexibility in non-clinical service reimbursement like peer support (United States Government Accountability Office [GAO], 2020 August; GAO, 2018 November; Mechanic, 2012). These flexibilities, along with the country's behavioral health providers shortage have led to 50 states and the District of Columbia adopting the peer support certification required for service reimbursement. Peer support has become the most covered recovery support benefit for Medicaid recipients with a mental health and/or substance use disorder (GAO, 2020).

Peer Support Role in Behavioral Health Treatment

In their peer support role, individuals share their personal mental health and/or substance use disorders experiences with persons working towards and/or who are in recovery (White, 2009). This unique mutuality of shared lived experience, also known as "peerness", can offer an understanding and acceptance often absent in traditional provider-patient relationships (Mead & McNeil, 2006). Peer support should complement, not replace, clinical services and these services can "…offer emotional support, share knowledge, teach skills, provide practical assistance, and connect people

with resources, opportunities, communities of support, and other people" (Mead et al., 2001).

Prior Research

Peer support is neither mutual self-help, nor clinical care— it has become a specialized resource category for mental health and/or substance use disorder treatment (White & Evans, 2014). In shifting practice and policy to incorporate this new category of worker, the behavioral health field faced numerous challenges, including role confusion and inconsistent adherence to evidence-based practices in peer support training, and a lack of widespread adoption of supervision standards (Kent, 2019; Westat, 2015).

White (2009) challenged researchers to identify possible long-term effects on individuals in recovery and on the behavioral health field from the rapid professionalization of peer support services. However, throughout expansion of peer support services, research has primarily focused on investigating outcomes, not on the individuals supplying peer support services (Otte et al., 2020; Scott et al., 2011). There are some studies describing the likely benefits to individuals from working in the peer support role. These benefits include strengthening the person's social support network and increasing their self-esteem and self-confidence (Gillard et al., 2015; Walker & Bryant, 2013). However, there are few studies exploring the social process of moving from a patient in care to a peer support working in the behavioral health field and any impact from their new role on personal recovery.

Green et al. (2019) stated individual having more time in recovery before starting a career in the treatment field and with higher monthly attendance at mutual aid groups served as protective factors against relapse. In their research, they reported a 14.76% relapse rate for individuals in their sample of recovered addiction professionals and felt this was a conservative estimate because it did not include individuals who relapsed and then left the treatment field. Relapse rates among these workers is likely much higher. The National Institute on Drug Abuse [NIDA] has reported relapse rates for people with substance use disorders generally range between 40-60% (2020, July).

Other research has examined how factors in the workplace influence personal recovery. Bailie and Tickle (2015) found sustained remission in peer supports was linked to role clarity, professional support, along with perceived team member acceptance/belonging and feeling valued for their work. Gethin (2008) claimed individuals with lived experience of alcohol use disorders working in treatment faced more risks to recovery and wellbeing compared to similar individuals not in this role.

Moll et al. (2009) found without specific strategies to support peer supports and their workplace environment, clients would receive less than optimal benefits from services. Vrinda et al. (2021) reported individuals in the role faced a lack of understanding of the purpose of peer support among co-workers and supervisors. They had pay inequities compared to individuals in similar roles not in recovery and insufficient training and development. Stewart et al. (2008) concluded lack of accepted ethical and practice standards by the field may increase risks to peer supports who were without adequate support and supervision.

Simpson et al. (2014) evaluated a training and implementation pilot for mental health peer supports and found individuals often faced challenges as they entered the field. Participants felt a lack of ongoing training and development made their transition more difficult. Surey et al. (2021) noted experienced peer supports moving into more clinical roles recognized their risk of relapse was higher due to new job demands. Participants saw compassion and support from their agencies as key in successfully navigating this transition.

Gaps in the Literature

Since White issued his challenge in 2009, researchers have worked to fill this mandate, with some focusing their work on more mature peer supports (Surey et al., 2021) and a few examining individuals in recovery working in more clinical roles (Green et al., 2019). There are few studies which describe workplace onboarding (Vrinda et al., 2021; Simpson et al., 2018). Additionally, a limited number describe work related stressors increasing relapse risk in peer supports (Gethin, 2008; Stewart et al., 2008). Fewer still identify protective factors against relapse (Surey et al., 2021; Green et al., 2019; Bailie & Tickle, 2015).

Consequently, a gap in the literature remains around how transitioning into the peer support role and subsequent workplace experiences impact an individual's personal recovery. Lack of data sufficiently describing the patient to peer support transition is a concern, given the role's rapid expansion in the behavioral health workforce. This research could be useful to agencies in several ways. First, agencies could use this information when developing peer support onboarding processes.

Second, they could apply findings to improving training and supervision programs for these workers.

Study Aim

In response to the identified knowledge gaps, this manuscript aimed to explore the transition from patient to peer support specialist as a social process during individuals' first three years of working in mental health and substance use disorder treatment.

Method

Using a constructivist grounded theory approach, I was informed by the tenants of pragmatism and symbolic interactionism throughout this study. Symbolic interactionism conceives identity of self as a continuous process emerging from interactions within and between individuals (Blumer, 1969). It contends the names individuals call themselves shape their actions with individuals and/or groups in their social world.

According to pragmatism, individuals construct personal, subjective, and social meaning in their world through process, and respond to changing perceptions of their environment by continually adjusting their actions in the social world (Glaser, 1998). Interactions are dynamic, interpretive, and essential to how individuals create and change meanings and actions. For this reason, motivations behind behavior cannot be understood from a detached vantage point, nor apart from context (Blumer, 1969).

In this study, I applied my knowledge of these core tenants to the overall study design, with each informing development of the initial interview guide. Symbolic

interactionism offered a framework to understand the meanings peer supports made from adopting the identity of a peer support, and how their training and supervision experiences shaped this meaning. Pragmatism offered a lens to view the context of participants' actions as they transitioned into a peer support professional identity and how these actions affected personal recovery.

Study Design

My practices throughout the study were informed by the structured, yet flexible methodology of constructivist grounded theory. This approach best fit with the overall study aim, allowing the researcher to focus on identifying individual perceptions, tactics, and meanings, and interpreting how participants constructed their realities (Charmaz, 2014). There were three data collection components in the study, including 1) reflexive field notes, 2) in-depth interviews (n = 23), and 3) member checking interviews (n = 2).

Recruitment and Sample

After receiving study approval from the [University of Louisville's] Institutional Review Board, I initially recruited participants from community behavioral health treatment programs using convenience and snowball sampling. I distributed the approved recruitment flyer through email and postings on provider listservs.

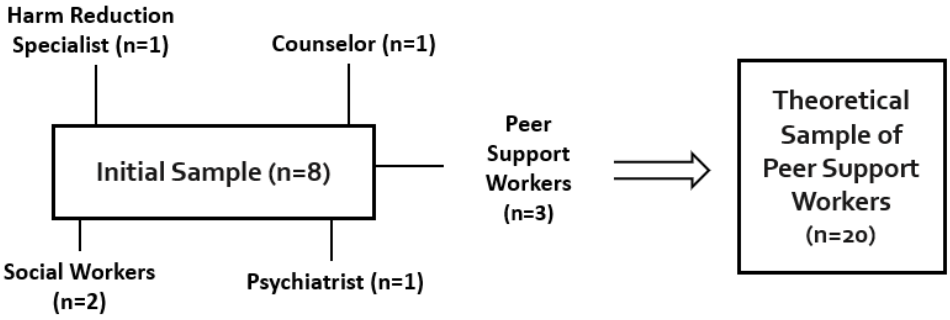
Individuals gave consent before becoming part of the study and received a $20 Amazon gift card as an incentive. See Figure 15 for a sampling diagram. Early on, I was intentional in recruiting a diverse sample of treatment providers entering the behavioral health workforce within the last three years (n=8). Providers interviewed in the initial stage of sampling included a psychiatrist, a counselor, social workers, a harm reduction

specialist, and peer support workers. Through taking this approach, initial interviews offered insight into the spectrum of early career training and supervision experiences for a range of provider types within the behavioral health workforce.

As I explored an emergent lead in meaning making of these experiences by individuals working as peer supports, recruitment narrowed to individuals employed in this role entering the field within the past three years (n=20). In this manuscript, I have only included only data collected from the 23 peer support interviews. Use of theoretical sampling in this manner allowed the researcher to further develop research aims and refine developing theoretical concepts (Charmaz, 2014).

Figure 15

Sampling Diagram



Data Collection

To best understand an individual's personal meaning making of workplace experiences, I conducted in-depth interviews using an interview guide (See Appendix A). Interviews are useful as the primary data collection method for facilitating free flowing, open dialogue with participants and appropriate for discussing sensitive issues such as

personal recovery from a mental health and/or substance use disorder (Creswell & Poth, 2017).

Tenants of symbolic interactionism and pragmatism guided initial interview guide development, along with workforce development literature produced by subject experts from organizations such as SAMHSA, the Addiction Technology Transfer Center [ATTC], Mental Health America, and NAADAC, the Association for Addiction Professionals. After conducting early study interviews, the researcher assessed the guide for question relevance and comprehensibility, then made revisions where appropriate.

Due to social distancing restrictions from the COVID-19 pandemic, I conducted interviews online through Microsoft Teams and by telephone when participants lived in an area with low internet bandwidth. Interviews ranged from 45 to 95 minutes in length, with an average interview time of 71 minutes. All interviews were recorded, then transcribed verbatim with participants using pseudonyms to protect privacy and confidentiality. The researcher engaged in field notes and reflexive memo writing to build awareness of personal bias, to reflect on ideas to explore in coming interviews, and conceptualize theoretical ideas developed while interacting with participants.

Analytic Strategies

To analyze study data, the constant comparative method embedded within constructivist grounded theory was used. It requires researchers to continually move between data collection and analysis (Glaser, 1969). In this study, the researcher detected gaps in knowledge through continually collecting, studying, and comparing

data with these explored in later interviews. In constructivist grounded theory, coding is the needed link between data collection and the explanation of this data (Bryant & Charmaz, 2007). It gives the researcher opportunity to contextualize what is emerging out of the data, then connect this to participant action and meaning making (Charmaz, 2014).

The researcher conducted initial, line by line open coding through applying gerunds as codes (—ing words) and through separating data into broader concepts. In addition, I applied in-vivo coding to dissect, scrutinize, compare, conceptualize, and categorize these data. Initial coding focused on the individual's language, processes, actions, and meanings (Corbin & Strauss, 1990). The researcher developed focused codes through moving from data to data, looking for what appeared frequent and what seemed significant (Charmaz, 2014).

From this process, broad categories emerged including *'nobody prepared me for how hard it was going to be'*, *'putting my recovery on the backburner'*, and *'needing to make a change'*. Memo writing and situational analysis mapping were done to further analysis. Through going back and forth between data collection and analysis during axial coding, category to category relationships with distinct properties and dimensions developed. One example is the *'crossing a bridge of understanding'* code linked with *'coming to terms with the work'*. *'Creating boundaries'* and *'seeking support'* were subcategories linking the two categories.

Theoretical Coding and Saturation

To conceptualize how substantive codes interrelated to one another within the research's central aims—understanding the transformation process from patient to peer support for participants—the researcher applied theoretical coding (Glaser, 1998). Through this work, the social process model of *'Developing a Peer Support Professional Identity'* emerged. In determining the point of theoretical saturation, the guidelines issued by Glaser (1978) and Morse (1995) were applied, including: a) prolonged engagement in the field, b) thick, rich description, c) inter-rater reliability, d) framework development, e) peer review, f) clarifying researcher bias, g) member checking, and h) triangulation.

At the start of their interviews, participants completed a short demographic survey. See Appendix B for the Demographic Survey. Descriptive demographic data collected through the survey was uploaded into Microsoft Excel. After this, the researcher analyzed the data for frequency distributions. See Table 2 for all demographic data collected. MAXQDA, a qualitative data management program was used for organizing the coding process.

Study Rigor

To increase study rigor, an individual skilled in qualitative methods who was not involved in either data collection or initial analyses completed an interrater reliability assessment with the researcher. This assessment produced a Cohen's Kappa test statistic of .95, indicating excellent agreement (Cohen, 1960). Member checking with participants around emergent concepts and themes occurred throughout data

collection and analysis. To clarify issues and develop the social process model framework, other analytic tools were employed during the study, including memo writing and situational analyses through positional and situational mapping (Clarke et al., 2017).

Results

Sample Characteristics

There were 13 female and ten male participants (n=13, n=10). Over half (n=13) earned 30,000 or less in their work as a peer support. The participants' time in recovery ranged from one to ten years, with more than half (n=15) in recovery three years or less. Ten (n=10) were employed at the same organization where they received treatment.

Workplace settings for the peer supports included: 1) long term, abstinence only residential programs (n=9), 2) mental health court or drug court (n=4), 3) outpatient behavioral health (n=4), 4) 28-day residential crisis unit (n=4), 5) integrated primary care (n=3), 6) adult or youth recovery center (n=2), 7) hospital (n=1), 7) ob-gyn practice (n=1), and 9) on an overdose quick response team (n=1). Seven individuals (n=7) had more than one peer support role at an agency and five (n=5) worked in more than one county.

Six individuals (n=6) filled more than one peer support role in their organization and five (n=5) worked in more than one county. Individuals typically took on multiple roles when needing to cover the duties of when a co-worker left their agency. In these instances, participants shared many of their co-workers quit since the pandemic began due to their fear of COVID. In one northern county, individuals believed it was only recently they had seen high COVID transmission rates like they did in [city name].

Several had co-workers quit over this and they said community members were frightened. Study participants worked in multiple counties when a co-worker had left their agency and when employed in a pilot project like the overdose quick response team and for a company that owned multiple ob-gyn clinics. In two of these situations, the participant's employer had plans to hire additional workers in the coming months. These participants would then help train the new peer support specialists.

Table 2

Sample Characteristics

Characteristic	***n***	**%**
Gender		
Female	13	56
Male	10	44
Race/Ethnicity		
Black	2	9
White	21	91
Highest Educational Level		
Master's Degree	1	4
Bachelor's Degree	3	13
Associate/Some College	11	48
Technical College	2	9
HS Diploma/GED	6	26
Annual Salary		
$50,001-S60,000	2	9
$40,001-$50,000	7	30
$30,001-$40,000	1	4
$20,001-$30,000	12	52
$20,000 or less	1	4
Age Range		
50-60	2	9
40-49	6	26
30-39	9	39
20-29	6	26

Years as Peer Support

3	7	30
2	7	30
1	4	17
Less than 1	5	22

Years in Recovery

10	2	9
9 to 7	3	13
6 to 4	3	13
3 to 1	15	65

Worked Where Treated

Yes	10	43
No	13	57

Workplace Setting*

Abstinence Based	9	30
MH or Drug Court	5	17
Outpatient	4	13
28-Day Residential	4	13
Integrated Primary Care	3	10
Recovery Center	2	7
Hospital	1	3
Ob-Gyn	1	3
Overdose Response	1	3

Workplace County Classification**

Large Central/Fringe Metro	3	11
Medium Metro	10	36
Small Metro	2	7
Micropolitan	4	14
Noncore	9	32

*Participants Worked in More Than One Role

**Participants Worked in More Than One County

Peer Support Professional Identity Development Social Process Model

In this study, the researcher grounded the Peer Support Professional Identity Development social process model in the data, it comes directly from the perspectives and beliefs voiced by study participants (Charmaz, 2014). This social process involved six distinct belief phases, including: a) *'where I need to be'*, b) *'the next day, you are in charge'*, c) *'consumed by the work'*, d) *'crossing that bridge of understanding'*, e) *'coming to terms with the work'*, and f) *'feeling like a professional'*. From the interview transcripts, the researcher developed in vivo codes and used to these in naming each phase in the model.

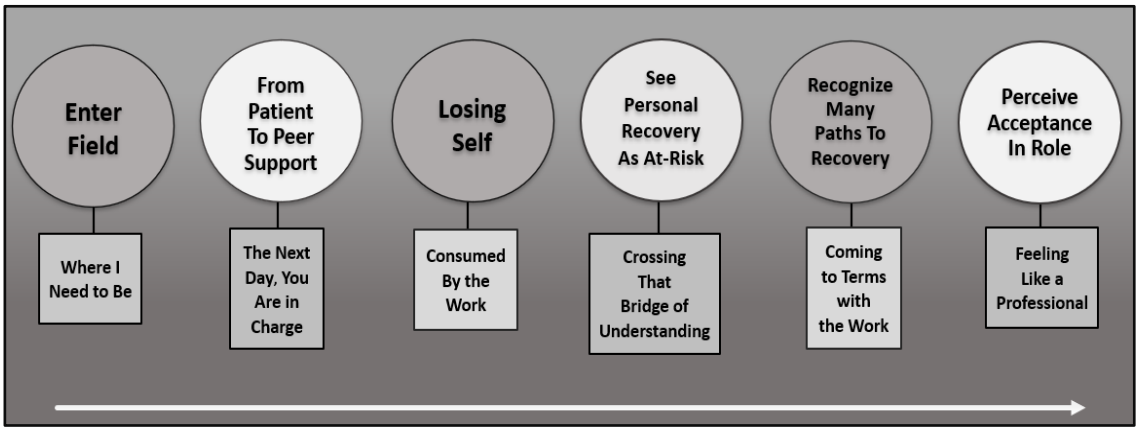
In the model's first phase, '*where I need to be'* was connected with individuals' perceptions of becoming a peer support as fulfilling their purpose in life. In the second phase, '*the next day you are in charge'* was related to individuals entering the field and realizing they felt unprepared to take on the peer support role. In the third phase, *'consumed by the work'* represented individuals losing their sense of self as a person in recovery due to work demands, in the fourth phase, *'crossing that bridge of understanding'* represented individuals recognized personal recovery was at-risk. To prevent relapse, they set boundaries for their peer support role and sought recovery support outside the workplace.

In the fifth phase, *'coming to terms with the work'* represented the point participants saw themselves as accepting multiple paths to recovery, including medication assisted treatment. In the model's final phase, *'feeling like a professional'* related to participants' perceived acceptance by others within their organization and

when they felt community partners acknowledged the value of peer support. The coming section will examine each phase of the model and quotes by participants will illustrate the meaning of that phase. See Figure 16 for a model of this social process.

Figure 16

Peer Support Professional Identity Development Social Process Model



Social Process Model Phases

Where I Need to Be

In this first phase, many individuals (n=16) recognized their jobs before treatment now lacked meaning for them and perceived becoming a peer support as *'where I need to be"* to fulfill their purpose in life. Eli stated "My sponsor and the [treatment] site administrator told me about it and encouraged me to apply. And when two or more people tell you the same thing, that's God talking to you through them". Cooper shared "I have a lot of life experience from what I have endured. I think, God put me where I need to be".

Mateo saw becoming a peer support as "I am living for my purpose, doing what God put me here for". For participants like Layla, *'where I need to be'* meant taking a leap of faith and pursuing peer support certification. She shared "Before, I felt like being a bookkeeper was just a job…I didn't feel like my life had meaning, that it had [any] purpose. I always feared to change careers but finally decided to go for it".

For some participants who saw becoming a peer support as their purpose in life, *'where I need to be'* was also linked to a desire to emulate those peer supports playing a significant role in their lives while in care. John shared for him:

> Someone came into my life during treatment and gave me hope, when I didn't have any hope. They gave me the support I needed, but didn't co-sign off on my BS. I wanted to be able to do that for someone- to say its ok, you aren't alone in this.

Adrian said "I was a felon with a long criminal history, I had trouble staying sober. I didn't believe in myself but they [peer supports] did".

While most individuals perceived *'where I need to be'* as fulfilling their calling in life, others had more pragmatic reasons for choosing this path. Two participants (n=2) saw becoming a peer support as a stepping-stone to more clinical positions. Others (n=4) perceived their long criminal record left them few career options, other than becoming a peer support. Greyson expressed this as "I went into this field because I didn't think there was anything else out there for me. They told me in treatment I should do it. They said because what else was I going to do with my record". Zoey shared a similar experience, saying "I didn't think there was anything out there for me

because of my past. I never thought I would be good at hardly anything. Those girls [peer mentors in treatment] convinced me that I'd be good at it".

Within all three groups, there were participants (n=11) while still care who started as noncertified peer supports, each were paid a $200 monthly stipend for this work. Three participants (n=3) in this category became certified peer supports for the agency they received treatment. Each left within 18 months of starting there for new positions outside that organization.

The Next Day, You Are in Charge

In transitioning into their peer support role, individuals felt unprepared to abruptly change identities, seeing this as going from being a patient one day to *'the next day, you are in charge'*. Once in their new role, participants came to recognize a paradox between their idealized conception of being a peer support and the day-to-day reality of the work. Luke shared "It was hard. One day you are a resident and the next day, you are in charge". David described his experience as:

> I had one year in recovery when I started and now you got me serving as the peer support for 16, 20 residents. So, I second guessed myself all the time. I was making decisions off the cuff, just hoping it all worked out after the fact.

Eli believed "To be honest, it feels like I was set up for failure. We weren't taught how to deal with situations, it was frustrating". Kara shared for her:

> It was a little chaotic, it was really hard for me to set boundaries with the girls that I had been in the program with. At the same time, they would just come up to where I lived [on treatment center campus] and ask me for stuff or just try to

> hang out with me. And I had to work really hard to set those boundaries, to not be their friend.

Ethan said "Like for a really long time when I first started working here, I had trouble with professionalism and communication because I had to switch from being a client to staff. It was like a whole different world for me". Aria felt "There wasn't much guidance, you just had to figure it out as you went".

For participants working in a community setting, *'the next day, you are in charge'* described a personal struggle in finding their voice. Rina shared as the only peer support working in her county's mental health court:

> I was in a room full of people- judges, lawyers, people with a Master of Clinical Social Work and they didn't think about what she [client] was going through. It was hard to say something, especially when everybody is agreeing with each other.

In her peer support role, Lily was not prepared for collaborating with the judge and prosecutor who sent her to jail in the past. When she joined the drug court team as a peer support, she felt "It was awkward at first because I had to make that switch from this was the person [judge/prosecutor] who would throw me in jail if I did something wrong, to now I didn't have anything to fear from them".

Consumed by the Work

Participants shared how early on after starting in the field, they unexpectedly stopped focusing on personal recovery and reported feeling unprepared for this experience. They had never expected to be *'consumed by the work'* to the extent self-

care was no longer the priority. Eli experienced this as “I got burnt out. I didn’t have my own identity in recovery anymore, I was just the person bringing other people to meetings. It was really hard to make that transition”. Kara shared “I got so involved. When I got home, I would collapse because I was so tired, I had nothing left to give, I was getting lost. All of my efforts and energies were here at work”.

Emily described *‘consumed by the work’* as “My personal recovery stopped being my priority, I was staying two or three hours over my shift to finish paperwork”. For David, this time looked like:

> I was so tired that I would want to just lay in bed and be a blob. I would go home and just totally ignore everything I had been telling my clients all day about self-care. I ran out of my psych meds and I didn’t refill them, and I would skip my therapy because I had paperwork to do.

For Mary, this meant “There was this time, it was like for three or four months; I just wasn't happy. I don’t want to say I didn't care about clients, but it became a job”. Ethan said “I started to not prioritize me because I was exhausted from helping people…And then you go home and there is all this stuff for your own recovery. It was just too much”.

Emerging from the data analysis was a range in participants’ difficulty adjusting to their new peer support role. Over half of participants (n=7) hired by the same organization they received treatment from reported struggling the most during the patient to peer support transition. Typically, individuals not working at the same

organization they received treatment were in recovery longer and were older. They expressed having less difficulty in switching from a patient to a peer support.

Crossing that Bridge of Understanding

Participants saw *'crossing that bridge of understanding'* as the time each realized putting their personal recovery on the backburner was not working. Individuals felt if they had kept going as they had been, relapse would have been a distinct possibility. Brody realized "I had two relapses before, I know the signs and so, I knew something had to change". Luke said "I realized it was time for me to back up, I want to help, not harm. Because the last thing they [clients] want when they are a hot mess is the person helping them being a hot mess too". Aubrey experienced this as "It was just a realization, a moment and then, I had to take a step back. I knew I was giving too much and not taking enough for me, for my self-care".

For other participants, they shared needing to face negative consequences before they were capable of *'crossing that bridge of understanding'*. While participants were reluctant to explicitly say they had relapsed after becoming a peer support, some alluded to it. Mateo believed "I didn't do anything until I suffered the consequences. I had to cross that bridge of understanding to see what I was doing wasn't working". For Greyson, he believed "Like, just telling me your work isn't your recovery isn't enough. I was in prison for 12 years and never learned my lesson, I have to get burned to learn". For Sherry this meant "I had to learn that I still need to self-care. If my battery is drained, it won't charge because it has nothing else to give".

After recognizing their risk of relapse, participants referenced actions taken to prioritize personal recovery once again. Some participants described tensions in their workplace with individuals, including with supervisors not in recovery. They described feeling as other, unable to share their struggles as a peer support to people without their shared experience.

Acting for these individuals meant not sharing their struggles with their supervisor and seeking support outside the workplace. Making changes for Mateo looked like "I reached out to my sponsor and my mentor because there is some stuff, I would never tell my boss". For Layla, acting meant:

> I didn't know about self-care and I thought I had a certain image to uphold. Now, I know how important that is- if I'm not good, I can't do good. I am getting strong enough to say no, to turn off my phone and take that time.

Mark shared, "I created a support network around me that keeps me accountable to self-care and that calls me out on my bullshit".

For some participants, *'crossing that bridge of understanding'* included setting limits for the first time in their role. For Carrie, a peer support supervisor, this meant "I set boundaries of when they [staff] could call, I taught them what was an actual emergency and what they should just send an email on". Sherrie shared "My coworkers told me I had to develop some calluses to stay in this job. I had to learn—you want to help people but sometimes you can't, and you can't want it more than them". Aria described this experience as "I got agitated, I wanted to cry all the time and I said to myself, you have to set some healthy boundaries, you can't be all to everyone".

For other participants, *'crossing that bridge of understanding'* meant they needed to acknowledge how unhappy they were at work. They felt to remain as a peer support, they needed to leave their employer. Eli shared "I left my first peer support job because I didn't feel like there was any support. I basically just got thrown into this work". Kara said "I left that job because of it [lack of support]. I decided I just wasn't going to do it; I was so burnout and tired. I needed a couple of months to then get back on track".

Coming to Terms with the Work

Participants discussed experiencing a shift in how they conceived recovery. Individuals would often refer of *'coming to terms with the work'* as a time they recognized personal bias had held them back from believing in multiple ways to reach recovery, including use of harm reduction, programs other than abstinence based 12-step, and use of medication assisted treatment [MAT]. After realizing this, they learned to accept recovery as an individualized process, acknowledging what worked for them might not work for their client. Peer supports found supervision and training as key in making this shift. They felt both helped them let go of old stigmatizing beliefs. Participants shared these activities opened their minds to accepting recovery as an individualized process, with multiple paths to reaching it.

Acceptance of MAT was one property of *'coming to terms with the work'*. Nearly every participant reported they stigmatized MAT when starting as a peer support and stated the topic was not covered or covered briefly. Individuals needed interactions with more clinical staff to let go of their old beliefs about MAT rooted in their own 12-step

based treatment experiences. For Adrian, learning to recognize MAT as a path to recovery looked like “My supervisor and me, we butted heads a few times over it [MAT]. I learned to be ok with it, she helped me to calm down and open my mind to MAT”. Aria believed “When I was at [treatment facility name], I was told taking medication means you are not in recovery at all. I had to learn that [MAT] is one form of recovery”.

Lilly shared “I would struggle with pregnant clients taking medication…[name] taught me not everybody's road to recovery is the same. It was hard and it’s still hard. But I had to gain a lot of acceptance about it”. Mary felt “Honestly, at first I was resentful [of clients taking MAT] because of how sick I was when I went through detox. I thought, I didn’t have anything to help me, so why should they”. Ethan shared “I was closed minded, I thought taking MAT meant it wasn’t real sobriety. Training taught me that’s not true”. John said “Me and my coworkers have been doing a lot of trainings and research on MAT ourselves because we're trying to be more open minded about it because it's helping a whole lot of people and it has a really bad stigma in the 12-step program in general, where people say it's not sobriety”.

Other properties of *‘coming to terms with the work’* were acceptance of harm reduction and non-12 step approaches to treatment. Alan believed “My recovery comes from do it or you die. But I've softened up because I have been learning other ways”. Cooper shared “AA beat it in my head that only way to recover was abstinence. I had to dig in and learn that any progress is progress period. If you stop injecting but still do drugs, that's still progress”. David believed, “I was closed minded because I thought

what worked for me in treatment meant it worked for other people too. I had to learn that just because AA worked for me, it might not work for you".

Feeling Like a Professional

During this phase, participants discussed *'feeling like a professional'* as when they perceived acceptance as a team member at their organization and when community partners acknowledged the value of peer support. Layla shared meeting with her former probation officer to advocate for a client and said:

> I actually liked seeing my old probation officer. She filled my head with all these good things that I am doing, how proud she was of me. It has made me walk with my head and shoulders back [and] feeling very proud. I feel like I am doing something right and that makes me feel good.

For Mark, *'feeling like a professional'* meant:

> So now, we have that trust and they [clinical staff] come to me about a patient and ask what's your opinion? When that happened- for once I just felt like a professional, that all the hard work of my own recovery finally paid off.

Rina shared what *'feeling like a professional'* meant to her:

> It floored me the first time they [drug court team members] …well…most of them, took me seriously. Another time, the judge said I want to hear what Rina thinks and he agreed with me over them! And it was weird for me. Like wow, he took my opinion over everyone else.

Sherry felt supervision was key to growing as a professional and stated "She [supervisor] shares info and resources. It makes me feel important, that I am part of something, it

teaches me to have an open mind. And hearing how other people it did- That can help me grow".

For others, *'feeling like a professional'* meant joining a new agency with coworkers and supervisors who respected their contributions to the work. After leaving her first job as a peer support, Kara joined an agency where she felt "Now, I am treated like an actual member of the staff. I am respected and treated like I matter". At her new organization, Zoey felt "Now, my supervisors are way more understanding. They come at things better and I know they get me". Others needed time to adjust before they trusted their new supervisor. Emily experienced this as "I was really nervous when I got the new supervisor because the last one was so bad. It was hard to open up but once I did, I learned a lot. I'm still working on it, trying to grow".

Discussion

This grounded theory study of 23 peer supports entering the field within the last three years highlighted the significant adjustment period during the transition from a patient in treatment to a peer support working in the field. Findings showed most participants employed at the same organization where they received treatment typically had less time in recovery (n=7). These individuals expressed the most difficulty in successfully navigating the patient to peer transition. They perceived they *'knew what worked'* for the program since they had succeeded in it. Furthermore, they reported difficulties in relating to their co-workers and supervisors without lived experience, seeing them as *'outsiders'*.

In the first phase of the social process model, the majority of participants (n=16) reported entering the field with an idealized meaning of being a peer support, seeing themselves as answering their calling in life- becoming a peer support was *'where I need to be'*. Two participants (n=2) over 40 years of age were more pragmatic, seeing becoming a peer support as a stepping-stone to more clinical positions. For other participants (n=4), *'where I need to be'* was rooted in perceiving life choices as limited due to their criminal record and reinforced by persons in positions of power around them.

In this study, nearly half of participants (n=11) started as a noncertified peer support while still in care and were paid a small monthly stipend of $200 for their work. Three participants (n=3) in this category started out working where they received treatment. Feeling the agency did not value their work and overloaded by the demands of the role, each left within 18 months for a new agency.

The findings of Faulkner and Basset closely resemble those seen in this study. While the research on this topic is limited, Faulkner and Basset (2012) found individuals experienced difficulties trying to maintain an identity as both a service user and peer support worker. The authors stated participants described feeling unprepared for this dual nature. They felt supervisors and co-workers failed to bring up the issue. Each believed supportive supervision could have helped ease this transition. Similarly, Simpson et al. (2018) examined peer support occupational identity over time in the field and found it evolved through the interplay between their lived experience, training, and

engagement in the workplace. This identity was liminal, with a contextual nature to it and positive and negative outcomes varied between the individuals.

In phase two of the model, participants felt unprepared once for their new responsibilities once in the peer support role, receiving little to no onboarding which resulted in them experiencing an abrupt shift from being a patient one day, to *'the next day, you are in charge'*. This finding is similar to prior research which found higher levels of confusion and conflict around the role as factors contributing to less successful implementation of peer support work (Mancini, 2018; Asad & Chreim, 2016).

In phase three, as the peer supports struggled to cope, participants reported becoming *'consumed by the work'* to the point of risking personal recovery. Contributing to this was a lack of sufficient onboarding leading to role confusion and peer supports feeling overwhelmed by their new position, which then challenged individuals' recovery behaviors. Relatedly, Debyser et al. (2019) found as peer supports become more experienced role confusion typically decreased and individuals' self-maintenance and personal development were less affected by workplace stressors.

In the fourth phase of the social process model, participants spoke of *'crossing a bridge of understanding'*. For most, this was admitting to themselves how much they had ignored personal recovery since becoming a peer support. This resulted in them creating boundaries in their work and seeking support from outside the workplace. Participants believed not instituting these changes meant relapsing in the coming months.

For others, *'crossing a bridge of understanding'* meant acknowledging how unhappy they were at work. They shared being exhausted, never feeling accepted by the non-peer supports in their organization and finding supervision experiences stressful. This acknowledgment led to these peer supports seeking new employment. Prior research has reported on the importance of co-worker and supervisor acceptance to peer supports. When peer supports perceived lack of connection to, and acceptance from their coworkers, they reported feeling isolated from, and inferior to, clinical staff. Supervisor understanding of the peer support role was key to greater job satisfaction and decreased turnover (Scanlan et al., 2020; Byrne et al., 2018; Kuhn et al., 2015).

In fifth phase of the social process model, participants would refer to *'coming to terms with the work'* as when they recognized their growth as a peer support, with training and supervision significant to their development. They let go of the narrow definition of recovery learned in their own 12-step treatment and came to acknowledge more than one way to recover. This typically meant accepting approaches such as medication assisted treatment [MAT] and harm reduction as ways to recovery. Most reported workplace supervision and training were key in making this shift.

Similarly, Krawczyk et al. (2018) reported stigma within the treatment field towards MAT with providers perceiving individuals as 'not really abstinent' and merely substituting one drug for another. Likewise, Narcotics Anonymous [NA] members believe recovery is based on total abstinence from all substances (White, 2011), that it is the precondition for "the pain of living without drugs or anything to replace them" (NA World Services, 2007, p. 24). For other participants, *'coming to terms with the work'* led

to participants enacting boundaries at work, recognizing they could not be all things to all people.

The social process model's sixth phase occurred soon after *'coming to terms with the work'*. For some individuals, *'feeling like a professional'* was associated with perceived coworker and supervisor acceptance as a member of the team and from community partners recognizing the value of their peer support work. For those participants that *'coming to terms with the work'* led to them seeking new employment, *'feeling like a professional'* meant transitioning into a new agency where they felt accepted and valued for their peer support work. Throughout the transition from a patient to a peer support, individuals reporting the most difficulty worked at abstinence only organizations where they received treatment.

Recommendations for Practice

Among study participants, the majority felt unprepared and lack confidence during their transition into a peer support role. They believed certification training instructors and their employer should have educated them in the importance of self-care and on placing boundaries in their work to prevent relapse. Once working, they failed to share their struggles with their supervisor, perceiving acceptance from others depended on them being strong and capable. Future research should investigate the how the transition into the peer support role impacts personal recovery.

Prior research has shown the importance of training peer support supervisors, to provide role clarity for new hires. However, Kentucky does not currently require supervisor training before employing peer supports. Researchers should advocate with

policymakers to make training mandatory. The social process model from this study may be useful in this training to demonstrate the risks to personal recovery when individuals start on this new career path. It could illustrate the importance of training and ongoing support to reduce role confusion during an individual's transition from a patient in care to a peer support working in the behavioral health field.

Participants reported a disconnect in the workplace between those with and without lived experience of substance use disorders, leading to a sense of other. To decrease new peer supports feeling as outsiders, it may be helpful for individuals with lived experience at their agency at least a year to provide initial certification training and deliver a structured shadowing experience during individuals' first weeks on the job. They could serve as mentors, stressing the importance of self-care and help navigate workplace stressors affecting personal recovery. As role models, they could accompany new hires to their initial supervision meetings and demonstrate best practices.

Through these mentoring experiences, new career peer support specialists could provide opportunities to observe the benefits from supportive supervision experiences. They could see the benefits of open communication in working through workplace issues even when the supervisor may not have any lived experience. For several participants in this study, they were the first peer support hired at an organization making this onboarding impossible. For this group as an alternative, the state could develop a formal peer support mentoring program, pairing these new hires with individuals working in a similar peer support role at nearby agencies.

Limitations

The present study is susceptible to various limitations. First, the participants interviewed were essential workers during the COVID-19 pandemic. When asked to reflect on past job stresses, increased workplace demands associated with the pandemic may have unknowingly influenced their responses. Second, qualitative research findings relate to a study's specific situation and context. Third, the present study is subject to recall bias. In the interviews, the researcher asked participants to retrospectively describe prior experiences influencing their professional development.

Conclusions

In this study, participants felt unprepared for the social process of transitioning from a patient in care to a peer support working in the field. Moreover, study participants saw their training and supervision as insufficient in preparing them for this transition. Within their first months as a peer support, individuals reported becoming consumed by their job to the point personal recovery was at-risk. Peers without supportive supervision lacked guidance for navigating this difficult period. To avoid relapse and continue working as a peer support, they believed they needed to enact changes including creating boundaries for their role and seeking support outside the workplace.

Study findings suggest a more structured onboarding process paired with ongoing opportunities for training and supportive supervision may be beneficial for peer supports when adjusting to their new role. Individuals trained to deliver reflective supervision in a supportive manner could offer a safe space to learn the coping skills

needed to address issues common to new peer supports. Future work should explore if a structured onboarding process, paired with ongoing training and supportive supervision are key factors in successfully transitioning from a patient to a peer support.

CHAPTER FOUR

PEER SUPPORT TRAINING AND SUPERVISION EXPERIENCES

Growth of the Peer Support Workforce

Over the last 20 years, the behavioral health field has transitioned to a system of care focused on meeting the individual needs of clients. In doing so, it moved away from a 28-day acute model of treatment (Substance Abuse & Mental Health Services Administration [SAMHSA], 2018; White et al., 2012). At the center of this new model is a focus on recovery and understood to be a self-determined process of change which allows an individual to live a fulfilled life (Davidson et al., 2007; New Freedom Commission, 2003). Peer support is central to the field successfully transitioning to this new system of care and intended to complement, not replace clinical services (SAMHSA, 2020; White, 2007).

Mead (2001) defined peer support as "A system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful". Flexibilities from the Patient Protection and Affordable Care Act and the Centers for Medicaid and Medicare recognizing peer support as an evidence-based practice have contributed to these workers becoming the fastest growing segment of the behavioral health workforce and their services becoming the most covered

Medicaid recovery support benefit (United States Government Accountability Office [GAO], 2020 August; Mechanic, 2012).

Nearly every state and the District of Columbia now offers the certification training required for service reimbursement and in 2020, approximately 30,000 certified peer supports were members of the behavioral health workforce. Through their services, the world of treatment has expanded far beyond the traditional clinical setting and into the communities of those served, including drug/mental health courts, federally qualified health/mental health centers, primary care, behavioral health outpatient services, peer run organizations, recovery residences, hospitals, and in long-term residential treatment (SAMHSA, 2020). Titles for the role may vary depending on the setting and state regulations. These titles include recovery mentors, peer support workers, peer recovery support specialists, peer support specialists, consumer-provider, peer recovery coaches, and consumer advocates. In this manuscript, the author will use the term peer support specialist.

Peer Support Training and Supervision Overview

The Substance Abuse and Mental Health Services Administration [SAMHSA] has repeatedly stressed peer supports are employed in a relatively new, non-clinical role not previously utilized by the behavioral health field to provide care. While individuals are 'experientially credentialed' to provide peer support, SAMHSA has cautioned this lived experience on its own is insufficient in preparing them for the day-to-day realities of the work (Center for Substance Abuse Treatment, 2009). To further develop their skills and

abilities, peer support specialists should receive professional development opportunities based in evidence-based practices (Ahmed et al., 2015, Salzer et al., 2009).

SAMHSA has emphasized supervisors are key in the successful integration of peer supports into the workplace and receipt of supervision, especially clinical supervision, rather than administrative, should be the priority for early career peer supports (SAMHSA, 2014). The four core functions of a clinical supervisor are to 1) teach, 2) consult, 3) coach, and 4) mentor/role model (SAMHSA, 2014). To ensure individuals deliver high quality supervision meeting the needs of peer supports, they stressed the importance of regular training in best practices for supervisors and organizational leaders (SAMHSA, 2014). Researchers have also called attention to the importance of ongoing training in developing peer support specialists (Simpson et al., 2014). However, peer support workers (89%) have reported they needed additional training and supervision to improve their skills and confidence in delivery services (Ahmed et al., 2015).

In shifting practice and policy to incorporate these workers, the behavioral health field failed to adequately address numerous challenges, including role confusion and inconsistent adherence to evidence-based training and supervision standards (Kent, 2019; Westat, 2015). In addition, clinical staff, supervisors, and organizational leaders often misunderstood and devalued peer support contributions (Doughty & Tse, 2011). In response, the SAMHSA Peer Recovery Center of Excellence [PRCE] recently identified workforce development as one of four core focus areas to enhance peer support workers' professionalization (PRCE, 2021).

The Government Accountability Office [GAO] reported on leading practices in state peer support certification, these included a minimum threshold of 40 hours for certification training, incorporating physical health and wellness into training and/or continuing education, requiring continuing education content to be specific to the peer support role, and state provided trainings to adequately prepare organizations to employ peers (2018, November). Over the last three years organizations such as Mental Health America [MHA] and NAADAC, the Association for Addiction Professionals have also proposed national standards in peer support certification.

Though various groups have proposed standards, the field has failed to reach wide-spread agreement around a unifying framework in preparing peer supports for their role and for supervision once these workers are in the field (McBain et al., 2021). Hence, individual states have taken it upon themselves to develop training and supervision practices unique to each one. The goal in developing both has been to make these workers eligible for Medicaid and other service reimbursement.

Kentucky is one such state and provides limited oversight for peer support certification, training, and in their supervision. Rather than require delivery of one core certification curriculum for training, the Cabinet for Health and Family Services [CHHS] approves agency developed versions. Twenty-six agencies (n=26) now use their version of an adult peer support curriculum for certification training and nine agencies (n=9) use their version of a youth curriculum. Each version's content must encompass the six core competencies as outlined in the role's authorizing regulations, these include problem solving, wellness recovery action planning, recovery process stages, effective listening

skills, establishing recovery goals, and using support groups to promote/sustain recovery (CHHS, 2020, October).

Once curriculum approval is obtained, the state provides no oversight to ensure fidelity to the content. Rather, agencies must monitor themselves, notifying the state when changing their curriculum (Bogarty, 2021, May 20). Certification training itself lacks a standardized framework for delivery and study participants reported agencies employed a wide range of approaches for delivery, including an intensive three-day method, to a seven-day one, a fourteen-day program, and a six-month training course.

In the state, supervision specific training is neither required nor offered. Instead, "…it is strongly encouraged supervisors of peer support specialists [PSS] participate in a Peer Supervisor Training and understand the role and function of the PSS" (CHHS, 2020, October). Individuals who work in any of twenty roles may provide supervision, including certified alcohol and drug counselors, licensed professional art therapist associates, licensed clinical social workers, marriage and family therapy associates, physicians, physician assistants, and advanced practice registered nurses (CHHS, n. d). Further, the regulations offer little guidance on the expected content of supervision, only stating it should be face-to-face, occur no less than twice per month with at least one individual supervision meeting, and last at least thirty (30) minutes in length (CHHS, n. d).

Need for Study

Prior research has suggested employers offering peer support specialists with ongoing training and supervision to increase their skills (Ahmed et al., 2015). Unfortunately, organizations unprepared for employing peer supports may fail to provide ongoing training and supervision meeting professional development needs. Moreover, peer support responsibilities may vary greatly, going outside the role's occupational boundaries when agency leaders and supervisors are not prepared to incorporate the role into their organization (Dickerson et al., 2016). When peer support specialists do not receive these professional development opportunities, they may not consistently deliver services based in best practices. When individuals in care do not receive needed high-quality care, we can see poorer client outcomes (SAMHSA, 2014; Institute of Medicine, 2012).

Because of the findings of McBain et al., 2021 and due to Kentucky's fragmented approach in developing the peer support workforce, we must understand the impact of these experiences on individuals entering the field within the last three years. However, there is little research on early training and supervision experiences of peer supports and even less on strategies used by these individuals to fill any perceived gaps in knowledge and skills once they are working in the field. We should investigate if peer support specialists take on similar attitudes and actions as seen when task-shifting, defined as moving delivery of a service from a more clinical to a less clinical provider. Prior research found though registered nurses felt unprepared for these new demands, many still delivered these services. Perceived loss of identity, lack of control, and

insufficient resources motivated them into acting (Feringa et al., 2020; Mijovic et al., 2016).

Study Aims

In response to these gaps in the literature, this manuscript aimed to:

1) Understand and describe effects from early career training and supervision experiences on peer support professional development.
2) Identify the actions taken by these peer supports to fill any perceived gaps in role related knowledge and skills.

Method

The researcher was informed by the tenants of pragmatism and symbolic interactionism through applying a constructivist grounded theory approach to the work. Symbolic interactionism conceives identity of self as a continuous process emerging from interactions within and between individuals. Within their social world, the names individuals chose to call themselves shapes their actions with others and/or groups.

Through use of process in their world, pragmatism believes individuals construct personal, subjective, and social meanings. They respond to changing perceptions of their environment by continually adjusting their actions in the social world (Glaser, 1998). Essential in individuals creating and then changing meanings and actions are dynamic, interpretive interactions. As a result, motivations behind an individual's behavior cannot be understood from a detached vantage point, nor be separated from their context (Blumer, 1969).

In this study, the researcher applied knowledge of these core tenants to the overall design of the study, with each informing development of the initial interview guide. Symbolic interactionism offered a framework to understand the meanings peer supports made from adopting their peer support identity, and how their training and supervision experiences shaped this meaning. Pragmatism offered a lens to view the context of participant actions as they transitioned into a peer support professional identity and how these actions affected personal recovery. It was useful in understanding how individuals used problem-solving strategies when they had limited knowledge and when working through challenges in their role.

Design

Constructivist grounded theory provided the best fit with study aims and offered a structured, yet flexible approach which informed the researcher's work. Through this constructivist lens, the researcher focused on identifying individual perceptions, tactics, and meanings, and interpreting how participants constructed their realities (Charmaz, 2014). The study had three data collection components, including 1) in-depth interviews (n = 23), 2) member checking interviews (n = 3), and 3) writing reflexive field notes.

Recruitment and Sample

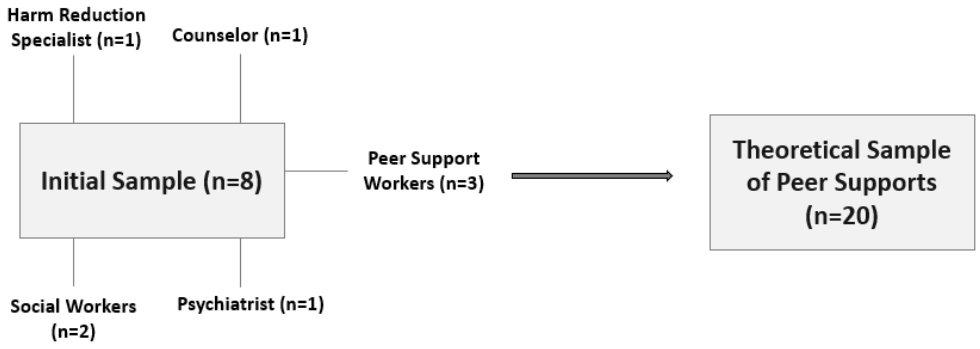
The University of Louisville's Institutional Review Board approved the study. The researcher first recruited participants from community behavioral health treatment programs using snowball and convenience sampling. Each participant consented before joining the study and received a $20 Amazon gift card as an incentive. Early on, the researcher was intentional in recruiting a diverse sample of treatment provider types, all

entering the behavioral health workforce in Kentucky within the last three years (n=8). Providers interviewed in the initial stage of sampling included a psychiatrist, a counselor, social workers, a harm reduction specialist, and peer support workers. Through taking this approach, early interviews offered insight into the spectrum of early career training and supervision experiences for a range of positions within the behavioral health workforce.

As the researcher explored an emergent lead in meaning making of these experiences by individuals working as peer support specialists, she narrowed recruitment to individuals employed in this role (n=20) and the researcher only included data collected from the 23 peer support interviews in this manuscript. Use of theoretical sampling in this manner allowed the researcher to further develop research aims and refine developing theoretical concepts (Charmaz, 2014). See Figure 17 for the Sampling Diagram.

Figure 17

Sampling Diagram



Data Collection

The researcher used in-depth interviews as the primary data collection method and an unstructured interview guide to facilitate free flowing, open dialogue with study participants. The goal was to best understand an individual's personal meaning making of workplace experiences and actions taken in response to these. When discussing a sensitive issue such as a participant's recovery from a mental health and/or substance use disorder, the researcher's use of interviews for data collection is appropriate (Creswell & Poth, 2017).

When developing the initial interview guide, the researcher was informed by symbolic interactionism and pragmatism. Other sources used included Kentucky peer support regulations, content from the state's peer support certification website, and the work of subject experts in peer support workforce development. Early on, the researcher assessed the guide for question relevance and comprehensibility, then made revisions when needed.

Social distancing requirements stemming from the COVID-19 pandemic required the researcher to conduct all interviews online through Microsoft Teams and/or through the telephone when individuals lived in an area with poor internet connectivity. The length of participant interviews ranged from 45 to 95 minutes and the average length of an interview was 71 minutes. With participants' permission, the researcher recorded interviews, later transcribing each verbatim. Participants used pseudonyms to protect privacy and confidentiality. To build awareness of personal bias, to reflect on ideas to explore in coming interviews, and for conceptualizing theoretical ideas fostered through

interactions with participants, the researcher engaged in writing field notes and reflexive memos.

Analytic Strategies

The researcher used the constant comparative method [CCM] embedded in constructivist grounded theory to analyze study data. Use of the CCM required her to continually move between data collection and analysis (Glaser, 1969). She detected knowledge gaps by continually collecting, studying, and comparing data, with these gaps explored in later interviews. Through using a constructivist grounded theory approach, the researcher could link data collection and explanations of this data (Bryant & Charmaz, 2007).

She contextualized what was surfacing out of the data through her coding and then linked this with participant actions and their meaning making (Charmaz, 2014). Through applying gerunds as codes (—ing words), the researcher did initial, line by line open coding and separated the data into broader concepts. To dissect, scrutinize, compare, conceptualize, and categorize data, the researcher applied in-vivo coding. Her initial coding focused on participants' language, processes, actions, and meanings made from experiences (Corbin & Strauss, 1990).

Through moving from data to data to look for what appeared frequent and what seemed significant, the researcher developed the study's focused codes (Charmaz, 2014). From this work, broad categories emerged including *'training wasn't that helpful'* and *'it's mostly a peer kind of consultation'*. During axial coding, the researcher developed category to category relationships with distinct properties and dimensions by

continually going back and forth between data collection and analysis. As an example, the code *'basically, on the job training is how they do things'* linked with the code *'supervision—it's just kind of random'*. *'I don't think they really put a lot of emphasis on training and development' and 'I just used my own personal experience'* were subcategories connecting the two.

Theoretical Coding and Saturation

Through applying theoretical coding, the researcher could conceptualize interrelationships between substantive codes, these interrelated to one another within the research's central aims—understanding the training and supervision experiences for individuals entering the field within the last three years, how their professional development was affected by these experiences, and in identifying strategies individuals used after training and supervision to fill perceived gaps in role related knowledge and skills (Glaser, 1998). The researcher applied the guidelines supplied by Glaser (1978) and Morse (1995) to determine the point theoretical saturation was reached, including a) prolonged engagement in the field, b) thick, rich description, c) inter-rater reliability, d) framework development, e) peer review, f) clarifying researcher bias, g) member checking, and h) triangulation.

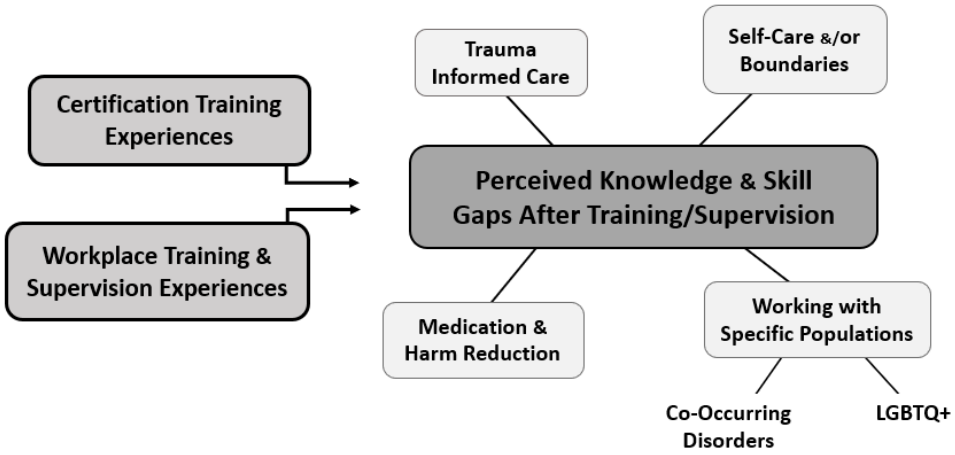
The researcher analyzed demographic data for averages and ranges in MAXQDA, a qualitative data management program, to organize her coding process, and to complete the interrater reliability assessment. To increase study rigor, an individual skilled in qualitative methods and not involved in either data collection or initial analyses completed an interrater reliability assessment with the researcher. This

assessment produced a Cohen's Kappa test statistic of .95, indicating excellent agreement (Cohen, 1960). Throughout the study, the researcher enhanced analysis rigor and credibility through member checking findings with participants around emergent concepts and themes. She employed other analytic tools such as memo writing and situational analyses to clarify issues and to develop the conceptual model (Clarke et al., 2017).

Results

Figure 18

Conceptual Model of Perceived Gaps After Training and Supervision



Sample Characteristics

There were 13 female and ten male participants (n=13, n=10). Over half (n=13) earned 30,000 or less in their work as a peer support. The participants' time in recovery ranged from 10 years to one year and more than half (n=15) had three years or less of recovery. Ten (n=10) were employed at the same organization where they received treatment. Workplace settings for the peer supports included: 1) long term, abstinence

only residential program (n=9), 2) mental health court and/or drug court (n=4), 3) outpatient behavioral health (n=4), 4) 28-day residential crisis unit (n=4), 5) integrated primary care (n=3), 6) adult or youth recovery center (n=2), 7) other healthcare settings including a hospital and ob-gyn clinic (n=2), and 8) as a member of an overdose quick response team (n=1).

Six individuals (n=6) filled more than one peer support role in their organization and five (n=5) worked in more than one county. Individuals typically took on multiple roles when needing to cover the duties of an individual who left their agency. Several participants shared many of their co-workers quit since the pandemic began due to their fear of COVID.

In one northern county, participants shared it was only recently they had seen high COVID transmission rates like they did in [city name]. Several had co-workers quit over this and they said community members were frightened. They worked in multiple counties when a co-worker had left their agency and when employed in a pilot project like the overdose quick response team and for a company that owned multiple ob-gyn clinics. In two situations, the participants' employer had plans to hire additional workers in the coming months and then, these participants would help train them. See Table Three for detailed sample characteristics.

Table 3

Sample Characteristics

Characteristic	*n*	%
Gender		
Female	13	56
Male	10	44
Race/Ethnicity		
Black	2	9
White	21	91
Highest Educational Level		
Master's Degree	1	4
Bachelor's Degree	3	13
Associate/Some College	11	48
Technical College	2	9
HS Diploma/GED	6	26
Annual Salary		
$50,001-S60,000	2	9
$40,001-$50,000	7	30
$30,001-$40,000	1	4
$20,001-$30,000	12	52
$20,000 or less	1	4
Age Range		
50-60	2	9
40-49	6	26
30-39	9	39
20-29	6	26
Years as Peer Support		
3	7	30
2	7	30
1	4	17
Less than 1	5	22
Years in Recovery		
10	2	9
9 to 7	3	13
6 to 4	3	13
3 to 1	15	65

Worked Where Treated		
Yes	10	43
No	13	57
Workplace Setting*		
Abstinence Based	9	30
MH or Drug Court	5	17
Outpatient	4	13
28-Day Residential	4	13
Integrated Primary Care	3	10
Recovery Center	2	7
Hospital	1	3
Ob-Gyn	1	3
Overdose Response	1	3
Workplace County Classification		
Large Central/Fringe Metro	3	11
Medium Metro	10	36
Small Metro	2	7
Micropolitan	4	14
Noncore	9	32

*Participants Worked in More Than One Role

**Participants Worked in More Than One County

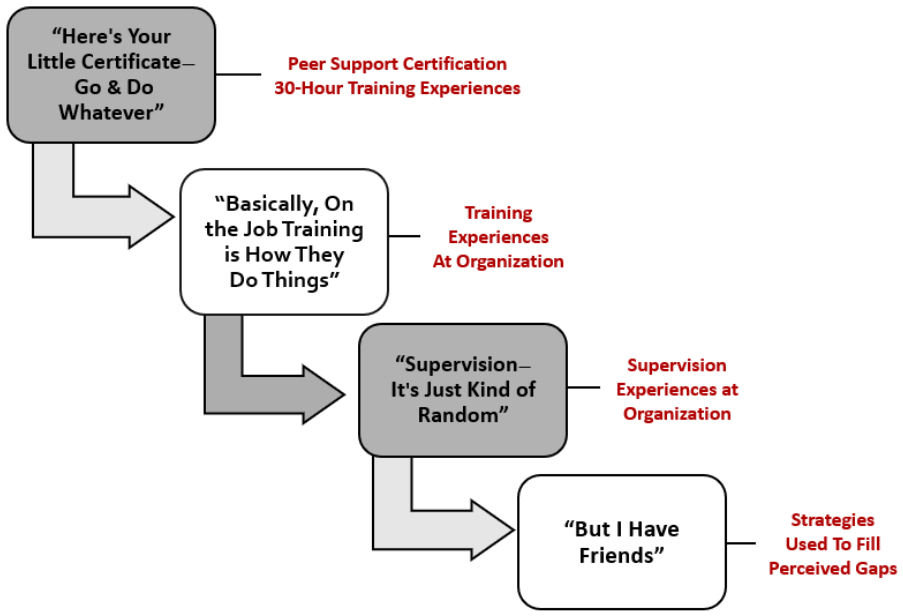
Categories

Emerging from data analysis were four categories occurring along a continuum with dimensions within these which reflected the individual nature of participants' experiences of training and supervision as a peer support. The first, *'here's your little certificate—go and do whatever'* described the 30-hour peer support certification training experiences. The second, *'basically, on the job training is how they do things'* described training provided by the employer. The third, *'it's just kind of random'* depicts participants experiences of employer delivered supervision once working in their role. The fourth category, *'but I have friends'* identified strategies participants have and/or

would use to fill perceived role related knowledge and skills gaps. See Figure 19 for a diagram of these categories.

Figure 19

Categories Emerging From the Data



Category 1, Here's Your Little Certificate— Go and Do Whatever

Peer Support Certification 30-Hour Training Experiences

To become a certified peer support in Kentucky, individuals must participate in a 30-hour training and pass its exam with a score of 70% or higher. In this study, individuals working at larger agencies with 30 or more staff members typically received this training from their employer. Individuals employed at smaller agencies were more likely to attend training outside their organization.

The total costs of the certification training and taking the exam varied by agency, ranging from a low of $200, to a high of $375. Even when their employer covered the

costs, providing the training and administered the exam on-site, participants knew the cost and said their employer had told them. While most employers covered the cost of the certification training/exam with no stipulations attached, this was not true for one participant. For Carrie, her employer taught the certification training/offered the exam and charged her $350. She explained this meant “They had a contract I signed where I had to keep working there for three years or I had to pay it back. It was staggered on how long I worked…like after a year of working, it went down some”.

When asked to describe their peer support certification training experiences, participants reported instructors covered a wide range of topics for the curriculum, with content varying from agency to agency. Rina shared “I learned how to be person centered. I learned how to use my experience to help others without making the focus be on me”. Mateo said “I learned how to be a leader, to be dependable and meet deadlines and set boundaries, and I learned a lot of ethics”. Layla reported “I learned a lot about boundaries from a standpoint of personal recovery, but also professional boundaries like relationship boundaries with your clients”. Aubrey said “A lot of that was learning about the differences in recovery, that there's no one path to recovery”. When asked to describe her certification training, Kara replied:

> It was kind of a watered-down therapy session for us, I felt. Like, we learned we had to really kind of check ourselves with our recovery process. And we learned how to tell our stories from a recovery standpoint, not from our sick story—like on the whole to not give people the depressing side of it and we learned kind of how to turn it into something positive.

Alan said “I learned how to make note templates [for billing]. I learned how to structure a note, to be articulate when writing it”. When asked how she was trained, Aria laughed and replied “You know what's funny, they really stressed the self-care in it but like how could I do that? I was working six days a week”. Luke said “I just learned every time point has to have documentation and did I utilize my lived experience with the client? If yes, then I can bill”.

Ultimately, from these observations we see a lack of uniform content in peer support certification training. Furthermore, while participants expressed significant variety in their training takeaways, many reported their certification training was of little help. This finding suggests when agencies use their own curriculum in certification training with no monitoring by the state for fidelity to content, this allows the organizations to define what are the key topics to cover and how to structure the experience in very different ways. Often agencies did not seem to use best practices in making these decisions.

During their interview, participants were asked to describe how their training covered best practices for working with vulnerable populations such as LGBTQ+ individuals, suicidal clients, and those with co-occurring disorders. Most participants received limited training in the topic. Mateo stated “They kind of really emphasized if you have any kind of prejudice or bias towards them [LGBTQ+ individuals], to get over it and just work with them and treat them like everybody else and you should ask what pronouns what they prefer”.

Zoey shared “They basically kind of teach you to talk someone down off the ledge. They give you statistics about suicide, like information on just how to talk to someone in general who is suicidal”. Carrie said “As far as an actual training about different mental health issues, no [I was not trained]”. John said “No, I don't think we did [learn about trauma informed care]. We kind of learned briefly how to check yourself—like if you had been through trauma and then you heard their [client’s] trauma, to be aware of counter transference”.

Some peer supports mentioned struggling with the amount of information they needed to learn in their 30-hour peer support certification training. Carrie took her training over three 11-hours days and shared “That was a lot, I feel like knocking it out in a weekend, like it's a lot of information and it's really exhausting”. David explained:

> We went over what recovery means to us, how we are different from like clinical services. We learned like the different roles that we play, about boundaries. It was a lot, really. I understand why they give you 2 weeks off to study because it's a lot of stuff.

Alan said “There was like a week-long training in [name of city], where they showed us the computer system, they went over policies, the whole HR entire thing and so, that was intense”.

Several individuals brought up feeling unprepared for their work after completing the certification training. Luke believed he should have received additional training before becoming a peer support and he emphasized “As front-line workers, we aren’t clinicians. You [organization leaders] need to be sure we are educated about

what's out there and what available for us". Similarly, John saw his certification training as "It was like, here you are, here's your little certificate— Go and do whatever. And then, they just basically throw you in the middle of it".

From the participants' descriptions, we see how instructors typically covered critical content in certification training including effective peer support delivery, such as trauma informed care, working with vulnerable populations, role boundaries, and self-care. Clearly emerging from participants' evaluation of training effectiveness is a process best described as piecemeal and one which lacks standards in its delivery. Collectively, we can evaluate participant perceptions of the usefulness and worthwhile nature of certification training as insufficient. Given most participants felt instructors inadequately covered and/or did not cover one or more topics during their training allowed us to make this claim.

Category 2, Basically, On the Job Training is How They Do Things

Training Experiences at the Organization

Structured training experiences are a key factor in shaping an individual's ability to succeed in their work, especially when new to their position. However, the majority of peer supports interviewed did not received this onboarding. Instead, their training was on the job, learning as they did the work. Greyson believed "[For training] They just asked if there were any questions I had and a lot of its common sense and I'm just going to be honest, ask anybody who is in recovery, we know how to talk to other people about recovery". Aria shared "It was horrible, I mean, there was no training. It was basically like here's how to use your computer".

Some participants made it a point to praise their employer, though they still expressed feeling their training was insufficient. Ethan perceived:

> As a peer support, there's a lot of on-the-job training. I work for a good organization and I'm grateful for the opportunity they gave me, but I don't think they really put a lot of emphasis on training and development.

Rina said “The one thing that I didn't have a clue about, that I got trained real fast in and that was just through work experience— is the personality disorders, like those are no joke”. Cooper shared “Of course, there's the nuts and bolts of learning the system itself, but it's mostly a peer kind of consultation [for training]”.

When supervisors and other staff are not well versed in what it means to be a peer support, training may often be neglected at an organization (SAMHSA, 2014). Similarly, in this study, the first peer support working at an agency received little to no structured training, with each responsible for designing the role’s scope of work. For Layla, this looked like:

> They really didn't train me because I am the only peer support here. They [clinical staff] kind of let me do what I feel is best for the clients and then they give me tools if I need them. So, like the relapse prevention plan, I knew I wanted to do one, that's something I wanted to do with the girls.

Sherry believed:

> I was the first peer support [name of organization] had there, and so I've been able to kind of set the tone, the requirements for being a peer support and the fundamentals of recovery and what's needed as a peer support.

Adrian worked a split position, half the time in a residential program and the other half in a hospital setting. She shared her training experience at the latter, saying “There's no one to really train me on my position up there. So basically, it was kind of giving me a list of people [patients] and they're like, here you go, do your thing”.

For other peer support specialists, agencies left training up to their co-workers. In sharing her experience, Lily said:

> You basically walked around with somebody for a day or two and that was pretty much it. Basically, on the job training is how they do things. But as far as actual real training on how to handle maybe an upset client, or somebody that's getting ready to get in a fight—No. Because I don't know how many times that almost happened and we weren't taught how to deal with that.

When talking about her initial on-the-job training, Mary stated:

> Honestly when I got hired—my coworker, she wasn't that helpful. I don't think she liked her job and I don't think she liked working the midnight shift. So, I learned from the mobile therapist and I just kind of had to teach myself, because my coworker just slept a lot, she wasn't really present…But yeah, I learned how to fend for myself.

Similarly, peer support specialists placed in supervisor positions (n=4) were rarely trained for their position and there was often no one in their organization they could ask questions. Zoey stated “I wasn’t trained in how to be a supervisor. I was kind of thrown into it, but I already knew from my recovery that you have to suit up and show up, to just deal with what is in front of me”.

Category 3, Supervision—It's Just Kind of Random

Supervision Experiences at the Organization

In Kentucky, individuals providing peer support supervision are not required to receive training in best practices and as result, supervisors at different organizations seemed to interpretate the supervision process and its goals differently. Some focused on more administrative duties and others viewing it as more clinical. Because of this, the peer supports had a wide range of experiences, with supervision more effective in professionally developing some participants than it was for others.

For Sherry, supervision looked like “They fill out an evaluation paper and I fill out an evaluation paper [after supervisor observes her teaching a class to clients]. My supervisor will tell me things that I did good on and tell me if there's anything she thinks I need to work on”. Mateo said “So my regular supervision, my weekly one, is done by my direct supervisor. And it's more of just a where we at with our projects, like do you need help with any of them kind of deal”.

Carrie described her supervision as only occurring during meetings with other agencies. She said “We get our supervision paper signed if we sit down and do actual trainings in Thursday meetings [with other agencies]. It's just kind of random”. Adrian shared “Basically, it’s like how you feel things are going, then possibly talk about any new things about to come up—if we were discharging a client, or if somebody's test result came back negative or positive”. Lily said “Obviously, we don't have enough time to go over each client, so we try to keep it to troubled ones, like how we're helping

them and then she [supervisor] tells us better ways to help them or what she wants us to incorporate".

Some participants brought up training did not stress the importance of self-care when you start out as a peer support. John believed:

> There wasn't a whole lot of emphasis put on training, self-care, like how are you taking care of yourself, how are you holding up in your own recovery. If I was a supervisor and was doing peer support supervision, those are the questions that I would ask.

Emerging from these participants' observations are properties of randomness, variability, and lack of fidelity to evidence-based practices during supervision. This may reflect a lack of training for supervisors in evidence-based practices for supports individuals working in recovery and working as peer supports.

While most participants did not find supervision helpful, several participants described finding interactions with their supervisor as positive, that the experience was helpful in growing as a professional. Aubrey shared "If there's anything I feel like I'm struggling with, I have no problem going to my supervisor and share it with her and see if she has anything that can help me with it". Eli believed his supervisor "…Does listen to me…he tries to help me figure out a solution to whatever I'm struggling with that I can't get past, which is a huge difference from the supervision I encountered before".

Some participants believed working with their supervisor in this manner served to build on their existing knowledge. They recognized what they learned in their own treatment was not how to best serve their clients. For Zoey, this meant:

> I'm familiar with the abstinence program, I can do that part in my sleep because that is what I did [for treatment]. But now, I am actually learning how to advocate for these women with the judges who placed them in treatment or who took their children away. So, that's with my supervisor—I meet with her once a week to learn how and what to do.

Alan said "I like the group idea better. I get to hear what other people are going through or what they need help with. I get to put that in my own bank of knowledge…without having to ask [supervisor]". Emily stated "I present to her [supervisor] things that I'm struggling with and she can help me learn from her years and years of experience in social work on what to do". The researcher theorizes individuals receiving more supportive and structured training and supervision were more likely to view and use the two as an opportunity to problem solve and grow as a professional.

Category 4, But I Have Friends

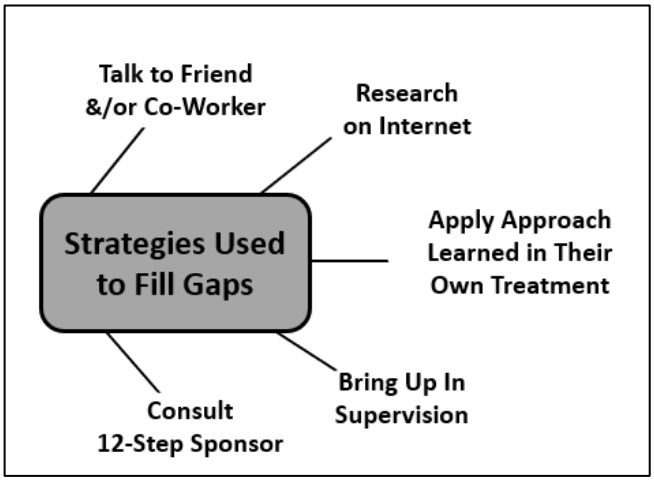
Strategies Used to Fill Perceived Gaps

After discussing training and supervision experiences, participants were asked to identify perceived role related knowledge/skill gaps and to describe strategies they have and/or would use to fill these gaps. When sharing their actions, most participants brought up using a combination of subjective experiences and personal relationships (See Figure 20). Few participants used supervision as an opportunity to problem solve or

to learn more about an issue. For the ones who did, these individuals typically had more time in recovery and did not work where they received treatment.

Figure 20

Strategies Used To Fill Perceived Gaps



Subjective Experiences and Personal Relationships

Individuals used subjective experiences and personal relationships in filling knowledge and skill gaps. This category first emerged when I asked participants to define substance use disorders and how they developed this definition. Aria said for her:

> It's kind of an AA thing. I would definitely define it as a chronic disease and there's an allergy that's associated with it…so the obsession and everything may be gone. But there are triggers to that allergy that still exist and so, if you're not using your tools and you get triggered, that's when that allergy and your addiction, can come out, you know what I mean?

Brody discussed how he developed his definition of substance use disorders and stated:

> Just from my own personal experience and the people that we work with and just seeing somebody who can go out and drink every now and then, still hold down a full-time job and you know, have a normal life. And then seeing somebody who is unable to drink like a regular person or you know, they can't really stop all on their own and stuff like that.

David said he developed his definition of a substance use disorder "Through being in treatment and working with my sponsor, from reading in the big book that chapter—It's called the Doctors Opinion and it just really breaks it down for us how the disease does center in our mind".

Participants were asked if they thought training adequately covered working with individuals in the LGBTQ+ population and if it did not, to explain any actions they took in response. Eli shared:

> Now that was another thing, like we were taught you know what words to use, but we weren't really taught what to do. But I have friends in all different diverse communities and everything else, so I have a little bit of a better understanding but there are some people that don't.

Greyson said he received no training in this topic and had yet to work with any LGBTQ+ clients. However, if he had a client from this population he thought that "We have a couple members of our staff actually, you know, in the LGBTQ classification. So yeah, I could go to one of them about it".

Participants were asked about their training in working with clients having co-occurring disorders. Adrian said:

> I learned [about co-occurring disorders] through being in treatment, you know, I spent 32 months all together in an inpatient treatment center while achieving sobriety myself. I learned so much when I was there—you got to think, there's 108 women under the same roof and that's when you really, really get to know these women and see like all the issues that they deal with.

Several participants brought up researching a topic through the internet to fill in a gap in knowledge. For Rina, she usually used the internet when she feels wants more information on issue, when asked how she knew to trust a source, she said:

> Because I only used like WebMD or another site that I know, like SAMHSA and things like that. I wouldn't go veering off course, because I know those sites are fairly accurate. They might all, you know, they might always depict the worst-case scenario in it, that's the one thing I have to remember but that's it, for the most part they are fairly accurate.

Cooper shared he never received training on the role of medication assisted treatment [MAT] in recovery and that:

> Me and my coworkers have been doing a lot of research on MAT ourselves on the internet because we're trying to be more open minded…it's helping a whole lot of people and it has a really bad stigma in the 12-step program.

Brody said “Luckily, I can learn on my own. I've always been this way…like I researched a whole bunch of different things and I have my own personal knowledge”.

Discussion

The purpose of this study was to qualitatively describe the training and supervision experiences of 23 peers supports entering the field within the last three years and the impact of these experiences on their professional development. The results illustrated the wide range of these early workplace experiences. Findings allowed the researcher to identify strategies the individuals used to fill perceived role related gaps in knowledge and skills.

Four major themes emerged from this work, the first two, *'here's your little certificate— go and do whatever'*, and *'basically, on the job training is how they do things'* described peer support certification and organizational training experiences. The words of the participants highlighted an overall lack of standards. From this work, we can conclude many organizations providing certification and on-the-job training failed to consistently adhere to best practices.

The third category, *'it's just kind of random'* identified the participants' wide range of supervision experiences. Some discussed receiving supportive, clinical supervision. Others received either an instructional and/or administrative form of supervision. In these experiences, they typically received instruction on program changes and client discharges. The fourth category, *'but I have friends'* provided insight into the personal nature of strategies used by participants in filling perceived knowledge and skill gaps.

Within the four categories were dimensions, reflecting the variety and range of participant experiences. For example, most participants believed both their training and

supervision failed to provide sufficient preparation for their role. However, some peer support specialists interviewed perceived certification training, onboarding, and supervision as effective. They reported use of best practices in these activities. For these individuals, certification training and onboarding were ways to become engaged with their work. Each activity socialized them to their new organization's practices and expectations. They were more likely to use supervision to share struggles and problem solve solutions. By doing so, they were provided ongoing developmental opportunities to grow professionally through workforce development experiences (Hoge et al., 2019; Colthart et al., 2018; White, 2017).

Conversely, agency leaders, supervisors, and co-workers expected the first peer support in their organization to train themselves. In addition, agencies allowed these peer support specialists to develop their scope of work and what topics they covered when working with clients. To ensure new employees are productive, engaged, and contribute to the work, organizations should use training, onboarding, and supervision experiences to socialize the person to agency expectations, standards, and norms (Nasar et al., 2019).

Since these agencies failed to utilize onboarding effectively, no psychological contract was made between the agency and the new employee. Effective use of onboarding can increase an employee's commitment to both the organization and to their work. It can increase employee job satisfaction and decrease turnover rates (Kowtha, 2018; Nasr et al., 2018; DeBode et al., 2017; Klein et al., 2015). Further, when front line workers like peer support specialists have high work intensity and perceive

low organizational openness to change/low support, they have higher rates of burnout and lower rates of engagement (Skinner & Roche, 2021).

When agency administrators and supervisors lack sufficient training in the peer support, role confusion can occur as participants reported in this study. This inadequate agency preparation prior to implementing peer support services can have multiple consequences. For example, in this study administrators and supervisors expected participants to take on tasks outside the scope of peer support work.

These organizations may have created a peer support role to obtain Medicaid funding without adequately training agency administrators, supervisors, and staff to effectively utilize peer support specialists. This may have led to poor onboarding experiences for the participants and contributed to the role confusion seen in the study. It appears these organizations did not account for the additional training and supervision demands coming from hiring these workers. This finding reflects resource dependence theory. Organizations may shape their activities and functions to match with funding requirements and to pursue new funding streams (Hillman et al., 2009).

Lack of support for these individuals may have consequences within and outside the workplace. Insufficient professional development can decrease worker effectiveness. As a result, clients may have poorer outcomes, including leaving the program early and relapse shortly after completing the program. These outcomes may make it more difficult for clients to achieve sustained recovery.

In employing strategies to fill perceived gaps in role related knowledge and skills, most individuals discussed using what worked for them in treatment. They relied on

friends and coworkers they saw as experts. Subjective experiences and personal relationships were key in the peer support's understanding of an issue and in how they approached filling in gaps. However, there was liminality in the thinking of many participants. They assumed knowing one person who was LGBTQ+ or having been in treatment with someone with co-occurring disorders meant understanding what all individuals in these populations might want and need in their care.

Participants struggled to see individuals in each group as just that—individuals. When we fail to see each client as unique, we are in conflict with the core values at the heart of person-centered care. Person-centered care requires us to perceive each client as an individual. We must consider the person's particular needs and wants throughout their treatment.

These experiences, especially the role confusion and lack of support by supervisors and co-workers, may impact a peer support's personal recovery. It is important to note findings from the work of Bailie and Tickle (2015). They examined factors in sustained remission for individuals working in the peer support role. They reported recovery over time was linked to role clarity, supervisor support, perceived acceptance/belonging by their co-workers, and with feeling valued for their work.

Limitations

The present study is susceptible to various limitations. First, participants interviewed were essential workers during the COVID-19 pandemic. When asked to reflect on past job stresses, their increased workplace demands associated with the pandemic may have unknowingly influenced responses. Second, the present study is

subject to recall bias. In the interviews, the researcher asked participants to retrospectively describe prior experiences influencing their professional development. Third, qualitative research findings relate to the study's situation and context for data collection. Fourth, this study focused on peer supports' perceptions of their training and supervision. Future work should examine this issue from the viewpoint of supervisors, as well conduct a comparative analysis between the two groups.

Practice Implications

In this study, individuals reported a wide range of training and supervision experiences, with many of these lacking fidelity to best practices in professional development. Participants viewed their training and supervision as insufficient in preparing them for the work. To fill perceived role related knowledge and skill gaps, the peer supports employed a range of strategies, including researching the issue on the internet, consulting their 12-step sponsor or a friend, with few asking their supervisor for help.

Findings from this study are similar to prior work examining workers engaged in task-shifting activities. Researchers found when a task shifted from a clinical role to front line workers, they were more likely to still provide it even when they felt they lacked the skills. They felt they lacked the power to refuse.

These findings and prior research support practice changes through delivery of high-quality training and supervision opportunities to increase peer support professional development. The literature strongly supports combining these activities. In insolation, each are less effective in building skills and increasing self-efficacy than when paired.

Given the wide range of training content as discussed by study participants, we recommend offering a core curriculum standardized for certification training, in adopting structured onboarding for new hires, and for increasing use of evidence-based practices in supervision through state sponsored supervisor training.

Conclusions

Future research should explore if providing a state sponsored training to supervisors before they work with peer support specialists decreases role confusion as seen in this study. Researchers should examine the impacts of providing individuals with a continuum of professional development activities throughout their career as peer support specialists. Further research in this area could build upon our work, to improve organizations' delivery of training and supervision, equipping these workers with the skills needed to consistently provide clients with high quality services.

CHAPTER FIVE

RECOMMENDATIONS TO IMPROVE PEER SUPPORT REGULATIONS IN KENTUCKY

Rationale for Policy Paper

Since the Centers for Medicare and Medicaid Services [CMS] identified peer support as an evidence-based practice in 2007, this segment of the behavioral health workforce has rapidly expanded. Through peer support specialists working directly with clients while in care and by supporting them in sustaining long-term recovery, their services offer opportunities to improve client outcomes and alleviate the strain on the system coming from the behavioral health provider crisis.

Though SAMHSA, Mental Health of America, and other organizations have proposed national standards in peer support certification, the field has failed to reach wide-spread agreement around a unifying framework in preparing peer supports for their role and for supervision once these workers are in the field (McBain et al., 2021). Therefore, individual states have taken it upon themselves to develop certification training, onboarding, and supervision practices unique to each to make these workers eligible for Medicaid and other funding streams.

Kentucky authorized peer support services as a Medicaid billable service in 2014 and in 2020, over 1,000 individuals passed their certification exam. The University of Michigan Behavioral Health Workforce Research Center (2019) reported Kentucky has the fifth highest number of substance use disorder treatment facilities employing peer support workers in the country (4.54 per 100,000 population). Widespread use of peer support services by agencies throughout Kentucky is linked to the state's successful implementation of the Affordable Care Act.

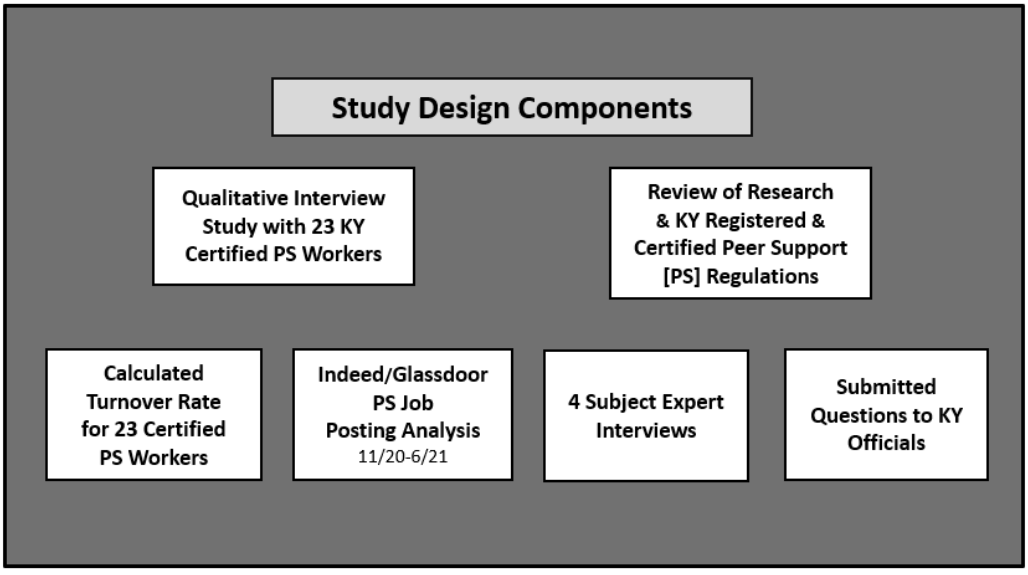
However, the state offers minimal oversight during the peer support certification process. Once in the field, there is no oversight over the professional activities of these workers. Kentucky only tracks the number of hours for supervision and continuing education. Consequently, we have limited knowledge of Kentucky's certified peer support workforce. We can only say 28 organizations offered 149 certification trainings, and 1,013 individuals passed their exam in 2020 (Bogarty, 2021, May 20).

Kentucky has not circulated standards of practice for the certified peer support workforce nor introduced a common code of ethics for these workers to follow. A lack of guidelines makes it difficult for us to judge the peer support specialists' performance against the field's accepted standards. Moreover, Kentucky does not track the number of certified peer support specialists working in the field, nor where they are employed, or the services they supply to individuals with mental health and substance use disorders.

We lack information on how agencies use onboarding, supervision, and continuing education to grow these workers. It is difficult to connect these activities to peer support specialist development nor if they affect service delivery. Without this data, it is harder for the state to evaluate how peer support services affect client outcomes. Knowing this, my goal when developing this paper was offering Kentucky's leaders actionable recommendations for policy and practice change. Through these changes, we can ensure the certified peer support workforce in the state continues to grow professionally now and in the coming years. See Figure 21 for a visualization of the study design components.

Figure 21

Study Design Overview



Review of the Literature

During the first phase of the study, I extensively reviewed the literature. Initially, I reviewed the role of workforce development in skill progression and effects on client outcomes from providers engaging in these activities. Then, I examined Kentucky regulations for peer support certification and registration and compared to these practices nationally. Third, I studied various state needs assessments of their peer support workforce. Finally, I looked at how states responded to the needs assessments and strategies employed in developing their peer support workforce and in planning for the future. In the coming sections, I offer readers a comprehensive accounting of Kentucky regulations governing peer support certification and registration. Within this report, I have incorporated additional findings from the literature review.

In-Depth Interviews with Certified Peer Support Workers

Throughout the late fall of 2020 and winter of 2021, I conducted a research study for my dissertation. Qualitative methods informed its overall design. In collecting and analyzing study data, I applied constructivist grounded theory. To further our understanding of the issues around the role in Kentucky, I used the data collected from in-depth interviews with 23 Kentucky certified peer support specialists all entering the field within the last three years.

In the interviews, we discussed their certification training, onboarding, continuing education, and supervision. With participants, I explored how these early career experiences affected skill development and the peer support's professional identity. After discussing certification training, onboarding, and supervision, I had each

participant describe any perceived gaps in role related skills. Then, they were asked to describe how they filled these gaps.

Four Subject Expert Interviews

To guide thinking when developing the policy paper, I interviewed four subject experts and used the data collected to refine my understanding of key concepts. First, I interviewed a regional representative from the ADA National Network. The interview covered key factors within in the Americans with Disabilities Act protecting employment rights of individuals in recovery. In our earlier interviews, most peer support specialists did not know their mental health and/or substance use disorder entitled them to protections and reasonable accommodations under the Americans with Disabilities Act. The purpose of the interview was to confirm with the ADA representative which protections they should have received and what the law requires of their employer.

During our interview, the representative explained employers could not discriminate against individuals with mental health and/or substance use disorders during the hiring process and once they are in the role. Further, as long as their request was reasonable, their employer should have given them time to attend AA meetings and meet with therapists as needed. However, individuals with substance use disorders are only protected by the ADA if they remain abstinent. Any ADA protections cease if they used the substance again.

In the second interview, I talked with an African American female psychiatrist working in the West End of Louisville. Her father was a longtime advocate for people with substance use disorders and ran a recovery home in the West End until his death.

Her interview allowed me to conceptualize an evidence-based model for integrating and sustaining peer support work within a behavioral health agency. She employs six peer support specialists and pays their wages and program costs out of the practice's profits. Their work with clients includes partnering them in developing goals and identifying needed resources to sustain their life in recovery. Each peer support specialist assists their clients in developing healthy lifestyle activities. After this, they participate in these activities with clients. These activities may include bowling, exercising, volunteering, and going to the movies.

The third interview with the Executive Director of Mental Health America offered historical background information on the peer support workforce in Kentucky and she explained the state's rationale when developing the peer support regulations. Our conversation helped guide the questions asked of Kentucky state officials. For the fourth interview, I spoke with the Recovery Education and Learning (REAL) Program Director in Massachusetts. In Kentucky, youth and family certified peer support specialists must attend a 15-hour leadership academy prior to attending certification training. However, there is no regulation requiring adult certified peer support specialists to take a similar training.

Several participants interviewed became a peer support shortly after reentering the community from either long-term resident care or after being released from incarceration. In Massachusetts, they help prepare individuals in similar situations to succeed in their peer support job. They offer individuals with pre-certification training over 12 weeks and if individuals want, they can participate in a paid peer support job

internship to build their skills and increase their confidence in their abilities to perform the peer support job. He supplied information on the state's work in peer support professional development prior to them becoming certified. This discussion specifically prompted the recommendation for pre-certification training.

Analysis of Turnover Rate and Job Ads

Other data collection activities for this policy paper included determining the turnover rate among study participants within six months of their interview date. The peer support workforce has a high turnover rate, estimated between 40% and 50% (Lapidos et al., 2018; Saltzer, 2010). As well, I reviewed weekly peer support job listings for Kentucky on Indeed and Glassdoor from November 2020 through June 2021. In the ads, I looked for language describing duties outside the occupational boundaries of the peer support role. The manner role responsibilities were worded may indicate peer support role confusion by agencies posting these positions. The findings from these analyses are covered in more depth in a later section of this paper.

Questions to Kentucky State Officials

For the final step in the study, I checked my understanding of this complex issue through submitting questions to: (a) Kevin Winstead, Kentucky Commissioner for the Department of Professional Licensing within the Kentucky Public Protection Cabinet, (b) Cheryl Bogarty, Program Administrator for the Division of Behavioral Health within the Adult Mental Health and Recovery Services Branch, and (c) State Senator Julie Raque Adams, the sole legislator sponsoring Senate Bill 191 in 2020 amending peer support registration regulations.

To date, Senator Adams has yet to respond to the questions submitted to her on June 7, 2021. Over the last four weeks, I have sent Senator Adams four follow-up emails asking if she still wanted to respond. She has not responded to these emails. Throughout the process when needing further clarification on a point, I followed up with Kevin Winstead and Cheryl Bogarty, the two other state officials. Each has responded to both my original questions and any follow-up ones.

Questions Submitted to Kevin Winstead

The questions submitted to Kevin Winstead; Kentucky Commissioner for the Department of Professional Licensing included:

1. How were the forty (40) classroom hours of board-approved curriculum developed?
2. How were the standards of practice and code of ethics developed?
3. Do the registered alcohol and drug peer support specialists submit a signed copy to the board?
4. How was the board-sponsored supervision training developed and do you have the number of people taking this training in 2020 and in 2021?

Questions Submitted to Cheryl Bogarty

The questions submitted to Cheryl Bogarty, Program Administrator in the Adult Mental Health and Recovery Services Branch included:

1. How were the rubrics developed for the adult, youth, and family peer support curriculums?
2. Does an agency choose if they will develop a peer support code of ethics?

3. Once an agency receives approval to provide certification peer support training, are they responsible for notifying the state of any changes to their curriculum/accompanying materials after this? If yes, how many submit curriculum revisions in a year?

Questions Submitted to State Senator Julie Raque Adams

The questions submitted to State Senator Julie Raque Adams regarding Senate Bill 2020 included:

1. Who brought the legislation issue to you?
2. How did this person/organization demonstrate the need for amending current regulations?
3. What was your thought process behind amending the registered peer support regulations to:
    a. Reduce the required hours of experience/education?
    b. Reduce the required time in recovery before applying for registration from two years to one year?
4. Who did you hear from on amending the regulations?
5. What did these individuals/organization say about making these changes?
6. What pushback did you receive on amending the regulations?
7. How did you respond to this pushback?

Importance of Peer Support Workforce Development

In the coming section, I first summarize the role of workforce development, then describe the Substance Abuse and Mental Health Services Administration's work in developing peer support core competencies. Third, I describe identified gaps in workforce development for the behavioral field generally and for peer support workers specifically. Finally, I have outlined efforts to professionalize peer support and illustrated how evidence-based, high quality training and supervision can develop early career peer support specialists' abilities in the core competencies.

Sufficient provision of a well-trained workforce is at the heart of an effective behavioral health service delivery system capable of improving the health and wellbeing of the population (Hyde, 2013). Leaders within the behavioral health field have named workforce development as a core component in ensuring "…There is a workforce of appropriate size, composition, and competency to address mental health and substance use related needs in a specific geographic area or the nation at large" (Mental Health Technology Transfer Network, 2020).

Peer Support Core Competencies

SAMHSA (2015) identified 12 core competencies specific to peer support work in the behavioral health field. Core competencies are the clusters of knowledge, skills, and attitudes individuals need to perform a role or function within the workplace. These competencies are based in guiding principles identified as essential in mental health and substance use disorder care. These are (a) recovery-oriented, (b) person centered, (c) voluntary in nature, (d) relationship focused, and (e) trauma focused. Policy makers can

use the competencies in developing certification standards and role expectancies. Organizations can apply them in guiding service delivery, in promoting use of best practices, and in evaluating job performance. Organizations can use these when developing training, onboarding, mentoring, and supervision professional development opportunities (SAMHSA, 2015).

SAMHSA's 12 competency categories for individuals offering peer support services include:

1. Engaging peers in collaborative and caring relationships.
2. Providing support through validating experiences, conveying hope, and celebrating efforts towards recovery.
3. Sharing lived experiences of recovery.
4. Personalizing peer support through recognizing and respecting an individual's path to recovery.
5. Supporting recovery planning.
6. Helping clinical staff in linking clients to needed resources, services, and supports.
7. Supplying information individualized to the person around skills related to health, wellness, and recovery.
8. Helping individuals to manage crises in different ways, including through recognizing distress, by creating safe spaces, acting to address a crisis, and by assisting in prevention tool development.
9. Valuing communication with the individuals they serve and with coworkers.

10. Supporting teamwork and collaboration.

11. Fostering advocacy and leadership growth.

12. Promoting their own growth and development to improve service delivery.

Gaps and Needs

Advocates and leaders in the behavioral health field have repeatedly said individuals entering the field lack the knowledge and skills needed to succeed in their work. In a report to Congress on the state of the substance use disorder treatment workforce, leaders from the Department of Health and Human Services [HHS] and SAMHSA (2013) stated the field has failed to address a growing workforce crisis in multiple areas, including: (a) inadequate compensation, (b) insufficient professional development, and (c) the high attrition rate among workers (p. 1).

These identified deficiencies are especially concerning for frontline workers like peer support specialists. In 2007, the Annapolis Coalition on the Behavioral Health Workforce reported peer supports and other non-degreed direct care workers typically interacted the most with clients but received little training and support from their organizations. Due to their own personal struggles with mental health and/or substance use disorders, these individuals could contribute valuable insights and understandings of the work of treatment and recovery. However, clinical providers and agency leaders discounted the unique contributions of individuals with lived experience (Cronise et al., 2016; Kuhn et al., 2015).

As the peer support workforce has grown, SAMHSA has repeatedly stressed the field must focus on developing peer support specialists and on their integration within the behavioral health care system. They cautioned agencies to not assume being 'experientially credentialed' on its own is adequate preparation for individuals moving into the role (Center for Substance Abuse Treatment, 2009). They encouraged advocates and leaders increase efforts to standardize their competencies through training and supervision. However, the behavioral health field has faced many challenges in shifting practice and policy to incorporate these workers, including role confusion and inconsistent adherence to peer support training and supervision standards (Kent, 2019; Westat, 2015).

Clinical staff and organizational leaders have often misunderstood and undervalued the contributions of peer support workers, even though they are the fastest growing segment of the behavioral health workforce (Doughty & Tse, 2011). These issues, along with insufficient employee development and lack of a career ladder for individuals in the position have contributed to the high turnover rates among these workers. Agencies should work to address these issues and reduce turnover. The estimated cost to replace an entry level employee is $4,169 when the researchers included related expenses such as recruitment, interviewing, hiring, and training (Society for Human Resource Management, 2016).

Efforts to Professionalize Peer Support Workforce

Legislative efforts have focused attention and funding on increasing professional development of peer supports. The 21st Century Cures Act required the Government Accountability Office [GAO] to report on the most common practices employed by states in peer support certification and ongoing activities to develop this workforce. They found leading practices by the states included: (a) requiring at least 40 hours for certification training, (b) incorporating physical health and wellness into training and/or continuing education, (c) making training content specific to the peer support role, and (d) states requiring and offering organizational training to prepare leaders, administrators, and supervisors for employing peers (GAO, 2018, November).

There have increasingly louder calls to professionalize the peer support workforce. Over the last three years organizations such as Mental Health America [MHA] and NAADAC, the Association for Addiction Professionals, proposed national standards for peer support certification. Two priorities in SAMHSA's 2019-2023 strategic plan are improved peer support service integration into the continuum of care and the sustainability of this workforce (2020, December 16). In 2021, the SAMHSA Peer Recovery Center of Excellence [PRCE] named workforce development as one of its four core focus areas to enhance peer support professionalization (2021).

However, the field has failed to reach widespread agreement both around a unifying framework in certification standards and in standards for onboarding and supervision to continue worker development once in the field (McBain et al., 2021). Consequently, states such as Kentucky have generated their own interpretations of best

practice and applied these ideas when creating peer support training and supervision regulations. The section immediately following provides a detailed description of Kentucky certified and registered peer support specialist regulations. Then, I briefly describe regulations differences between certified and registered peer support specialists in Kentucky. The policy paper concludes with a discussion of the implications coming from Kentucky's peer support certification regulations.

Role of Kentucky's Cabinet for Health and Family Services

In Kentucky, there are three categories of peer support certification —adult, youth, and family. In 2020, 1,018 individuals passed their certification exam with a score of 70% or higher. Of these, 973 passed the adult peer support exam, 28 passed the youth version, and 12 passed the family peer support exam (Bogarty, Kentucky Adult Mental Health & Recovery Services Branch, Email Communication, 2021, May 20).

The state limits the powers of the Cabinet for Health and Family Services in several ways. The branch is not charged with tracking the number failing the exam, which agencies employ these workers, nor how many certified peer support specialists work in the state. Its personnel have no ability to investigate an ethical complaint made against a peer support. Rather, the state has charged the Attorney General with this duty (Bogarty, 2021, May 20). However, peer support regulations do not state the Attorney General has been granted these powers. Furthermore, there is no information provided on the state's website directing people to the Attorney General's office if they wish to lodge a complaint against a peer support.

Peer Support Certification Training

Within the Cabinet for Health and Family Services, oversight of peer support certification falls under the Adult Mental Health and Recovery Services Branch [AMHRSB] and they have chosen a mostly hands off approach. For example, rather than mandate use of a common curriculum for adult, youth, and family peer support certification training, AMHRSB approves agency developed versions. Recently, there has been a sharp increase in the number of agencies wanting to offer certification training. This requires each agency to submit their curriculum to the state for review. In 2020, the branch approved 30 curriculum submissions. In 2021, department officials have approved 14 and have another 9 under review as of May 2021 (Bogarty, 2021, May 20).

Each agency's curriculum chooses how they cover the six core competencies outlined in the role's authorizing regulations, including problem solving, wellness recovery action planning, recovery process stages, effective listening skills, setting recovery goals, and using support groups to promote/sustain recovery (CHHS, 2020, October). Once organizations gain curriculum approval, the state provides no oversight to ensure fidelity to the content, nor to incorporate emerging evidence-based practices. Rather, agencies must police themselves, notifying the state when changing their curriculum. Halfway through 2021, the branch had received one curriculum revision for the year (Bogarty, 2021, May 20).

Likewise, certification training itself lacks a standardized framework for delivery, with agencies employing a wide range of approaches for delivery which include an intensive three-day version, a seven-day one, a fourteen-day program, and a six-month

training course. Only some agencies require individuals to take their certification exam on the last day of training, while others offer a two-week break between the two (Zero et al., 2021). In addition, each agency offering training develops their own code of ethics for certified peer support specialists. There are no requirements for individuals to follow the code or to submit a signed copy to the state (Bogarty, 2021, May 20).

Individuals are not required send a certification application to the state. Instead, they submit their application for peer support certification training to the agency. Each agency developed their application and chose what information to request from applicants. The state gives agencies the power to determine if individuals meet requirements as outlined in the peer support regulations. However, it does not expect agencies to notify the state when making these determinations (Bogarty, 2021, May 20).

Peer Support Supervision

In the state, training for the supervisors of certified peer support specialists is neither required nor offered. Instead, "…it is strongly encouraged supervisors of participate in a peer supervisor training and understand the role and function of the peer support specialist" (CHHS, 2020, October). It is unclear the number of supervisors pursuing this training on their own.

Individuals who work in any of twenty roles may provide supervision, including certified alcohol and drug counselors, certified psychologists, licensed professional art therapist associates, certified/licensed clinical social workers, licensed marriage and family therapy associates, licensed professional counselor associates, physicians, certified alcohol and drug counselors, physician assistants, and advanced practice

registered nurses (CHHS, n. d). Further, there is little guidance on the expected content of supervision. Regulations state only that it should be face-to-face, occur no less than twice per month with at least one individual session, and should last at least thirty minutes in length (CHHS, n. d).

Role Requirements and Responsibilities

Kentucky regulations specify the criteria for adult, family, and youth peer support specialist certification and outline the responsibilities of each of the three roles. It is important to note, in the regulations the state does not require a minimum time in recovery for individuals before applying for certification.

Adult Peer Support Specialists in Kentucky

Requirements for adult peer support specialist certification include:

1. Being at least 18 years of age, with a high school diploma or General Equivalency Diploma [GED].
2. Having a current or past diagnosis of a mental health, substance use, or co-occurring mental health/substance use disorder.
3. Receiving or having received treatment for the disorder/s.
4. Demonstrating a pattern of recovery.
5. Completing adult peer support specialist training approved by the department or receiving a training waiver.
6. Completing, maintaining, and submitting documentation of at least six (6) hours of related training or education in each subsequent year (908 KAR 2:220).

Responsibilities of a certified adult peer support specialist include:

1. Using relevant personal stories to assist other consumers through experience.
2. Serving as a role model to a consumer.
3. Encouraging consumer voice and choice during care plan development and implementation (908 KAR 2:220).

Support may be provided upon a consumer's request through a) attending team meetings on behalf of the consumer, b) accompanying the consumer to meetings, c) empowering the consumer to have the confidence to be a self-advocate, d) helping providers and other individuals understand the importance of integrating consumer voice and choice in services and support within a system of care, and through e) promoting socialization, recovery, self-advocacy preservation, and enhancement of community living skills for consumers (908 KAR 2:220).

Family Peer Support Specialists in Kentucky

For certification, family peer support specialists must first attend a 15-hour Kentucky Family Leadership Academy [KFLA] training delivered by one of ten state approved agencies. The goals of the KFLA include strengthening an individual's leadership skills, increasing their abilities to become leaders in the community, increase comfort in sharing their personal story, and to create a 'Family-Driven' and 'Youth Guided/Driven' System of Care (Kentucky Partnership for Families and Children, 2021).

Eligibility criteria for certification as a family peer support specialist includes:

1. Being at least 18 years of age, with a high school diploma or GED.
2. Self-identifying as having lived experiences as the parent or other family member of a person receiving/has received services from at least one child serving agency related to a mental health, substance use, or co-occurring mental health and substance use disability.
3. Completing an approved core competency training or receiving a training waiver.
4. Completing and submitting documentation of receiving at least six hours of related training/education every year after certification (908 KAR 2:220).

Responsibilities of a certified family peer support specialist includes:

1. Serving as a role model for clients and their families.
2. Using relevant personal stories to teach through experience.
3. Encouraging client and family voice and choice during development and implementation of plans.
4. Supporting clients and their families by attending team meetings with them upon request.
5. Empowering a client and family to have the confidence to be self-advocates.
6. Helping clients and families enhance relationships with community partners.
7. Helping other individuals working with a client's family understand the importance of integrating family and youth voice/choice in services/supports within the system of care.

8. Completing, maintaining, and submitting documentation of at least six hours of related training/education every year after certification (908 KAR 2:230).

Youth Peer Support Specialists in Kentucky

Individuals seeking certification as a youth peer support specialist must attend the same 15-hour KFLA as do individuals pursuing family peer support specialist certification. Criteria for certification as a youth peer support specialist includes:

1. Being a transition-age youth or young adult between 18 and 35 years of age.
2. Having a high school diploma or GED.
3. Having lived experience.
4. Having an emotional, social, behavioral, and/or substance use disability.
5. Receiving or have received state-funded services from at least one child-serving agency related to the disability.
6. Discussing the experience of receiving state-funded services from at least one child-serving agency on their application short-essay form.
7. Demonstrating experience with leadership and advocacy in behavioral health.
8. Demonstrating efforts at self-directed leadership development (908 KAR 2:240).

Responsibilities of a certified youth peer support include:

1. Using relevant personal stories to teach through experience.
2. Serving as a role model for clients.
3. Empowering and ensuring client voice and choice during plan development and implementation.
4. Supporting clients by attending team meetings when requested.
5. Supporting clients by improving their confidence to be a self-advocate.
6. Helping individuals working with youth understand youth culture.
7. Helping clients enhance relationships with community partners (908 KAR 2:240).

Kentucky Temporary Registered and Registered Peer Support Specialists

The state also recognizes the roles of temporary registered and registered alcohol and drug peer support specialists. Kentucky regulations specify the Board of Alcohol and Drug Counselors [KBADC] as responsible for the oversight of both roles. Though over 1,100 individuals became certified peer support specialists in Kentucky in 2020, far fewer individuals serve as temporary registered and registered alcohol and drug peer support specialists in the state (n= 95, n=15) (KBADC, 2021). Regulations governing the two roles differs from those for certified peer support specialists in several important ways. In the coming section, I have outlined these differences and then summarize the implications for the certified peer support workforce stemming from these differences.

Temporary Registered Peer Support Specialist Role

To become a temporary registered peer support specialist, an individual must:

1. Be at least 18 years of age.
2. Have a high school diploma or GED and submit a copy of their diploma, school transcript, or GED certificate to the state.
3. Self-identify as, and attest to, being in recovery for at least one year from a substance-related disorder
4. Submit a completed peer support specialist supervisory agreement, signed by the person and their board approved supervisor (201 KAR 35:055).

The board grants individuals a temporary registration for two years. At the end of the two years, they may apply for renewal an additional two times. Temporary status can last up to six years.

Registered Peer Support Specialist Role

To become a registered peer support specialist, an individual must:

1. Be at least 18 years of age.
2. Have a high school diploma or GED and submit a copy of their diploma, school transcript, or GED certificate to the state.
3. Complete 80 hours of board-approved work experience with individuals having a substance use disorder. Work experience must focus on advocacy, ethical responsibility, mentoring/education, and recovery/wellness support. Work experience may not include counseling. Of the total 80 hours of work experience, 25 must be under the direct supervision of either:

a. Certified alcohol and drug counselor with at least two years of work experience post-certification and who has attended board-sponsored supervision training.
b. Licensed clinical alcohol and drug counselor with at least one year of work experience post-licensure or who has attended board-sponsored supervision training.

4. Completing all required training hours, including:
    a. 16 hours of ethics training
    b. 10 hours of advocacy training
    c. 10 hours of mentoring/education training
    d. 10 hours of recovery support training
    e. 3 hours of domestic violence training
    f. 2 hours of training related to HIV transmission, control, treatment, and prevention.
5. Taking and passing the International Certification and Reciprocity Consortium examination.
6. Signing an agreement to follow the board approved standards of practice and code of ethics.
7. Self-identifying as, and attesting to, being in recovery for at least one year from a substance-related disorder.
8. Submitting two letters of reference from certified alcohol and drug counselors or licensed clinical alcohol and drug counselors.

9. Majority of the time live and/or work in Kentucky.
10. Completing the suicide assessment, treatment, and management training program as specified in KRS 210.366 (KRS 309.0831).

Supervision Requirements

For temporary registered and registered alcohol and drug peer support specialists, supervision must be at least two hours a month and occur at least two times a month. Content must focus on the recovery support domains of ethical responsibility, mentoring/education, advocacy, and recovery/wellness. Individuals may supervise a maximum of 12 persons acquiring experience for peer support registration. The board must approve all supervisors and supervision agreements. Within 12 months of board approval as a supervisor, individuals working as either a certified alcohol and drug counselor or licensed clinical alcohol and drug counselor must attend a free board approved training session in supervisory practices (KRS 309.0831).

Other Requirements

All individuals seeking registration as an alcohol and drug peer support specialist in Kentucky must pass the International Certification and Reciprocity Consortium's comprehensive peer support examination. They must agree to a common code of ethics developed by the board. They must a signed copy with their application to the state. None of these are requirements for certification as peer support specialist in Kentucky.

The continuing education requirements for registered peer support workers are also different from those governing certified peer support specialists. Individuals working as a registered peer support need at least ten continuing education hours

annually, four hours more than certified peer support specialists. The Kentucky Board of Alcohol and Drug Counselors outlined in the regulations the approved forms of continuing education and who can provide these activities. The board also requires registered peer support specialists to receive at least six hours continuing education annually delivered by a board approved provider in suicide assessment, treatment, and management (201 KAR 35:040E).

Sharp Contrast

When reviewing the regulations for certified and registered peer support specialists in Kentucky, a sharp contrast between the two was apparent. Unlike registered peer support specialists, for individuals seeking peer support certification there are a lack of standards for a minimum time in recovery, in the content and delivery of certification training, in the provision of supervision, and in the content of continuing education.

There are worrying to a lack of standards. Individuals serving on the front lines of behavioral health treatment need sufficient training, onboarding, and supervision to thrive in their work (Office of the Assistant Secretary for Planning and Evaluation, 2020, December; Hoge et al., 2019; Schoenwald et al., 2010). The implications stemming from this lack of standards will be covered in more depth in a coming section of this paper.

Table 4

Differences Between Certified and Registered Peer Support Regulations

Requirement	Certified PSS	Registered PSS
40 Hours of Required Training	**No**	Yes
Standard Training & Exam	**No**	Yes
Standards of Practice & Code of Ethics	**No**	Yes
Supervisors Trained in PSS Role	**No**	Yes
Require Training in Trauma Informed Care, Suicide Prevention	**No**	Yes
10 Hours Annual Continuing Education	**No**	Yes
Continuing Education PSS Role Focused	**No**	Yes

When I reviewed the regulations for certified and registered peer support specialists in Kentucky, I saw a sharp divide between the two types. The Board of Alcohol and Drug Counselors [BADC] have developed and circulated shared standards of practice and a common code of ethics for registered peer support specialists. However, the Adult Mental Health and Recovery Services Branch has neither standards of practice nor a common code of ethics for certified peer support specialists. The BADC requires individuals have one year in recovery before applying for registration.

Likewise, the BADC has regulations governing the content and delivery of training, and for continuing education topics and its approved providers. BADC has further mandated supervision must come from one of two provider types. The two types are either a certified alcohol and drug counselor or a licensed clinical alcohol and drug counselor.

However, the Adult Mental Health and Recovery Services Branch has not issued similar standards in these areas for certified peer support specialists. There are troubling implications in the state choosing not to do so. Individuals serving on the front lines of behavioral health treatment need sufficient training, onboarding, and supervision to thrive in their work (Office of the Assistant Secretary for Planning & Evaluation, 2020, December; Hoge et al., 2019; Schoenwald et al., 2010). The implications of these decisions will be covered in the next section.

Policy and Practice Implications

Before developing this policy paper, Zero et al. (2021) conducted a study of Kentucky's certified peer support specialist workforce in the fall of 2020 and winter of 2021. Study findings pointed to an overall lack of adherence to standards for: (a) the curriculum content and in delivery of certification training, (b) in the onboarding of new hires, (c) in required supervision, and (d) in agency understanding of the role's occupational boundaries (Zero et al., 2021). Lack of enforcement by state officials to ensure an agency's fidelity to their approved curriculum may contribute to the wide range of certification experiences reported by individuals.

Most participants reported supervisors and co-workers often misunderstood the role of peer support in behavioral health care. Earlier research reported role confusion as a contributing factor in high turnover rates for peer support workers (Almeida et al., 2020; Lapidos et al., 2018; Kuhn et al., 2015). Contributing to the issue may be the state's reluctance to issue shared standards of practice and a common code of ethics. Without both, role confusion as described by the peer support specialists in our study will most likely continue. This role confusion can contribute to high turnover among peer support workers.

Findings from Other Analyses

To determine turnover rates among study participants, I followed up with the 23 peer support specialists six months after they were interviewed. To obtain this data, sent emails and called participants, asking if they were with the same employer as when interviewed. From this work, I found a 21.7% turnover rate (n=5) among participants during the six-month period. This aligns with national findings placing the turnover rate among these workers between 40 and 50 percent. In this study, those peer support specialists more likely to have left their organization had less time in recovery and were newer to the field (entering within the last year).

Additionally, I reviewed 472 peer support job listings for Kentucky on Indeed and Glassdoor from November 2020 through June 2021. Through this review, I documented wording which pointed to role confusion. I found agencies regularly included duties outside the occupational boundaries and scope of peer support work.

The duties described by agencies in their ads typically fell into one of four categories:

- Clerical/administrative duties
- Monitoring/supervision of clients and their medications/vital signs
- Case management/clinical responsibilities
- Marketing/outreach duties

On the coming pages, I will present examples for each category. At the end of the section, I discuss the implications of findings from this peer support job listings review.

Category One

Clerical/administrative duties included:

1. Ensures facility cleanliness, maintenance, health/safety of the facility.
2. Enters complete and concise service notes in a timely manner consistent with all regulations and standards, documenting all interactions with client, family, involved agencies, supports, etc.
3. Ensures and checks proper admit and discharge paperwork of consumers.
4. Completes many clerical and administrative duties.
5. Corresponds with insurance companies throughout clients' course of treatment for continued authorizations for treatment.
6. Handles telephone contacts for crisis line/services, including documentation of calls.

7. Completes all shift documentation including (but not limited to) logs, report of incidents to staff, client program file updates, and incoming program paperwork for clients.
8. Supports and demonstrates fiscal responsibility through supply usage, ordering of supplies, and conservation of facility resources.
9. Implement and maintain a variety of procedures to evaluate programs and services.
10. Transport patients to appointments with [Agency] transportation services.
11. Ensure proper documentation of all groups and patient assessments.
12. Demonstrate punctuality, organization, and proficiency in all areas of scheduling, filling, meetings, and client relations.
13. Ensures fire and other safety measures are carried out, familiarity with basic functions of fire equipment, breaker panels and familiarize self with evacuation plans.
14. Responsible for handling prior authorizations for incoming clients and reoccurring authorizations.
15. Oversees day to day activities of the home, meal support, shopping, assist with cooking, overseeing meds, keeping the home in good working order etc.

Category Two

Client monitoring and supervision duties included:

1. Enforces program requirements.
2. Observes the consumer to monitor safety and assist in proper medication self-administration.
3. Ensure compliance with facility rules and regulations.
4. Completes [client] drug screenings.
5. Observes and communicates consumer behaviors and reactions to interventions.
6. Administer and document client urine screens.
7. Observes client/visitor behavior and reports abnormal behavior to supervisor.
8. Providing general supervision to residential patients, maintaining house rules/curfew.
9. Continues to evaluate the client's progress (or lack of) and document such.
10. Monitor all client chores and work projects.
11. Enforce program requirements.
12. Responsible for monitoring vitals, bed checks etc.
13. Administer medications to clients.
14. Control contraband in facility through observation, package searches, and room searches.
15. Provides direct supervision to participants.

Category Three

Descriptions of case management/clinical duties included:

1. Oversees services provided in assigned areas.
2. Co-facilitate evidence-based group therapy sessions.
3. Provides case management, resourcing, and service coordination.
4. Teaches recovery classes and grades client's homework.
5. Preferred skills: Mental Health First Aid, Trauma Informed Care, HIPPA, C.L.A.S. Standards, Motivational Interviewing, and specialized training in medical terminology and practices for designated health conditions.
6. Knowledgeable in the diagnosis and treatment of health, mental health, and substance use disorders among pregnant and postpartum women.
7. Conducts thorough assessments of patient needs, including arranging for specialized services.
8. Knowledge of Federal, State and Municipal laws and/or regulations that regulate the treatment of alcoholism and drug addiction.
9. Assists in treatment, substance use services, education, support, and consultation to families and in crisis intervention.
10. Assesses crises through risk assessment, management, crisis prevention, and intervention. Engages as appropriate to help de-escalate crises and promote stability/recovery.
11. Conducts home visits to clients receiving permanent supportive housing.

12. Implements and coordinates recovery plans for individual clients in assigned population group, including evaluation, consultation, education, and follow-up services.
13. Knowledge of rules, regulations, and laws pertaining to the care and treatment mental/behavior disorders and/or intellectually disabled.
14. Assists in implementing assigned client's treatment/recovery plan through provision of adjunctive case management services.
15. Provides psychoeducation with focus on illness management.

Category Four

Marketing/outreach responsibilities for peer support positions included:

1. Recommend and represent [agency name] at marketing events, community meetings, court dockets, etc.
2. Establishes and maintains referral relationships with therapists, law enforcement, hospitals, medical providers, and others that need to refer for SUD treatment, serving as the primary contact for these referrals, and working closely with intake team to get referrals into treatment.
3. Participate on Regional Grant Management and Implementation Teams for each of the [Agency] regions.
4. Partially responsible for managing all referral relationships, including coordination of in-person outreach and other communication channels that yields qualified leads.

5. Productively interacts with at least five stakeholders per day, at least two [of these] shall be new stakeholder prospects. Meaningful interactions include cold call canvassing, face-to-face meetings, facility tours, literature drop-off, email exchanges, etc.
6. Assists in building relationships with referring partners through meeting attendance.
7. Host exhibit tables at regional and community level events: back-to-school events, local fair, training events, etc.
8. Attend various community meetings and report relevant information to the Director.
9. Assists team to meet agency goals for number of placements by expanding the capacity for SE Specialists to focus on employment related tasks.
10. Responsible for outreach and engagement of potential consumers and partner agencies.
11. Assists the Director of Utilization Management and the Intake, Clinical, and Marketing teams in the creation of and execution of weekly, monthly, and quarterly marketing events and collaborations.

Implications of Findings

Previously in this policy paper, I offered the definition of peer support as a person who is both "…Offering and receiving help, based on shared understanding, respect, and mutual empowerment between people in similar situations" (Mead, 2001). Their services should be voluntary and offered in a non-judgmental manner. The

relationship between the peer support and client should be respectful and based in trust. These services should be collaborative and mutually beneficial. A peer support should never be in a position where they dictate what the client can do (SAMHSA, 2015). However, job responsibilities in the ads highlight agencies' apparent lack of understanding of these occupational boundaries.

An example of agencies' lack of understanding of the peer support role is expecting these workers to complete many clerical and administrative duties. Rather than place focus on person-centered care, paperwork is a core responsibility of the peer support. Likewise, in the monitoring/supervision category job ads, agencies used phases such as enforce program requirements and grades client's homework. Agencies stated in their ads the peer support was responsible for controlling contraband in facility through observation, package searches, and room searches.

Agencies expected the peer support to administer urine screens to their clients and document the results. Placing the peer support in the 'enforcer' role creates a power imbalance between them and the client. When the peer support is responsible for deciding if their client is making 'appropriate' progress in the program, this same inequity is seen. Each makes it impossible for individuals to offer their services as a peer support in a mutually supportive and non-judgmental manner.

Other agencies expected peer support specialists to take on a more clinical role, serving as the case manager. Duties in this category included providing psychoeducation with focus on illness management and conducting thorough patient need assessments. In Kentucky, a case manager must have at least a Bachelor of Arts or Science degree in a

behavioral science field such as psychology, social, or public health. Only four participants in the study would meet this education standard. Most individuals either lacked any secondary education or had less than two years of it.

When agencies expected the peer support to take on marketing and outreach duties, this often meant they had to meet referral quotas. For example, one agency expected the peer support to productively interact with at least five stakeholders per day through cold calling, being the facility guide, and dropping off literature. This appears directly opposed to the voluntary nature of peer support services. It leads us to the question- What did agencies expect the peer support to do if their program did not offer the most appropriate treatment for an individual? Researchers should investigate this question in future research.

To summarize, I found numerous examples of role confusion in each of the four categories of job help wanted ads. In describing position responsibilities, agencies often set up the peer support as the 'enforcer', creating a power imbalance between them and their clients. These findings point to need for the state to provide training for agencies in what it means to be a peer support. The state should also offer training to these agencies effectively implementing peer support work into the organization.

Recommendations

In the coming section, I offer detailed recommendations to improve practice and policy in several areas. These include strengthening regulations to improve peer support certification training and coaching organizational leaders/supervisors in effectively

utilizing peer support. I have identified cost effective opportunities for developing the professional skills of Kentucky's peer support workforce.

There are two overall goals in making these recommendations. The first is to ensure certified peer support specialists in Kentucky receive needed training and supervision. The second is to ensure individuals with mental health and substance use disorders consistently receive high-quality peer support services. Table 5 outlines each recommendation. Recommendation eight includes four parts, each is focused on further developing professional learning opportunities.

Table 5

Recommendations for Improving Policy and Practice

Recommendation	Actions
1	Conduct state-wide needs assessment
2	Create standards of practice & common code of ethics
3	Adopt standard curriculum/examination for use by agencies providing certification training
4	State mandate individuals must be in recovery from mental health &/or substance use disorder for at least 1 year before applying for certification
5	Require supervisors & agency representatives attend training on PS role/functions
6	Require supervisors & agency representatives receive continuing education annually focused on developing PSSs
7	State should revise supervision regulations in provision, type, & approved providers
8a	Offer pre-certification training/paid internship
8b	Increase continuing education requirements & identify content for these learning opportunities
8c	Increase professional learning through communities of practice
8d	Offer annual state-wide peer support conference

Recommendation One: Conduct a State-Wide Needs Assessment

I r*ecommend* state officials first collect additional data through a state-wide assessment of peer support specialists, their supervisors, and agency leaders. This can help ensure regulations changes best address issues I have identified through our research. This needs assessment would provide state officials with a clear picture of (a) the makeup of the peer support workforce, (b) the activities of certified peer support specialists in the state, (c) the provision of training and supervision to these workers, and (d) to identify existing beliefs and behaviors about the role held by agency leaders, supervisors, and peer support specialists.

State officials should partner with individuals having lived experience of mental health and/or substance use disorders in the assessment's design and in its evaluation. Iowa, Indiana, New Hampshire, Massachusetts, Oklahoma, Oregon, Pennsylvania, Tennessee, and Texas are among the states conducting this type of assessment of their peer support workforce. Project goals included describing the makeup of its workforce, the activities of these workers, and identifying their professional development needs. Outside the United States, Australia, Canada, and New Zealand have done similar work. The needs assessment would:

1. Identify characteristics of the peer support workforce and their practice environments.
2. Understand occupational roles, demands, and responsibilities.
3. Describe compensation, job satisfaction levels, and turnover intention in this workforce.

4. Identify agency and supervisor expectations of peer support specialists' knowledge, skills, and competencies.
5. Determine what peer support training and supervision gaps exist.

Recommendation Two: Creating Standards of Practice and Code of Ethics

After completing the needs assessment, I *recommend* the state use this data to create standards of practice and a common code of ethics for the three certified peer support roles. All individuals applying for certification must agree to comply with both and submit signed copies to the state. If complaint investigations or disciplinary action are later needed, these would be helpful in demonstrating the peer's agreement follow both. Once developed, I advise the state mandate use of both documents, as the Board of Alcohol and Drug Counseling does for registered peer supports.

Recommendation Three: Adoption of Standard Certification Curriculum and Exam

Recommendation three is for the state next adopt a standard curriculum and examination for certification. Further, it should require use of both by agencies providing training. The state should audit training content and delivery by regularly evaluating participants' training experiences and outcomes. Adopting both recommendations may ensure evidence-based practices are taught, delivered in a uniform manner, and as a result, deployed with greater regularity by peer support workers (Repper et al., 2021; Stuart et al., 2014; Center for Substance Abuse Treatment, 2009). Over time, consistent delivery of evidence-based high-quality services can contribute to improved outcomes for clients (Roche & Nicholas, 2019; Gates et al., 2010).

Recommendation Four: Require One Year in Recovery for Applicants

Other study findings by Zero et al. (2021) support further regulation changes, most participants reported feeling unprepared for transitioning from a patient in care to a peer support working in the behavioral health field, especially when they had a substance use disorder. It often took time in the field and them risking personal recovery before they felt comfortable in their new role. This is especially troubling considering a lack of state standards specifying how long individuals must be in recovery from a mental health and/or substance use disorder before becoming a certified peer support.

Individuals new to recovery with these disorders are vulnerable physically and mentally (Castillo et al., 2018). They need strong social support networks and adequate provision of behavioral health services once leaving treatment (Corrigan et al., 2020; Dixon et al., 2016). In individuals who misuse substances over time, progressively severe changes occur in the brain's structure and circuitry leading to compromised functioning. After an individual stops using the substance, these changes continue and can contribute to relapse. These individuals are most vulnerable early in their recovery, with over 60% of individuals relapsing within their first year of recovery (Ekhtiari et al., 2021; Moon & Lee, 2021; Sanna et al., 2021; Volkow et al., 2016).

However, without guidance from state, individuals can leave treatment one day and become a peer support the next. For this reason, I *recommend* the state enact a regulation specifying when individuals with substance use and mental health disorders can apply for peer support certification after being out of treatment for at least one

year. This regulation should specify if individuals who take medications such as buprenorphine, methadone, or suboxone are considered in recovery.

In 2019, states required individuals be in recovery an average of 18 months before applying for certification and most did not define if individuals taking medication assisted treatment were considered as in recovery (Videka et al., 2019 September). Arkansas requires individuals to have at least two years of abstinence-based recovery from lived experience with substance use disorders and/or mental health disorder (NAADAC, 2021). States used various measures in specifying when they considered treatment ended and when recovery began.

Georgia, Massachusetts, Michigan, Virginia all limit certification applications to individuals out of treatment at least a year. For example, the regulation for Massachusetts states individuals must "…Have been out of inpatient and/or outpatient hospitalization for over a year" (KIVA Centers, 2020). Florida, Ohio, Oregon, and Tennessee each require individuals have at least two years in recovery (Kiva Centers, 2020; Ojeda, 2019, April 3; GAO, 2018; Virginia Office of Recovery Services, 2017; Tennessee Department of Mental Health and Substance Abuse Services, n. d.).

Recommendation Five: Required Training for Agencies

Data analyses suggested agencies, supervisors, peer support specialists, and their co-workers had limited understanding of the role. This role confusion may explain the significant boundary overlap reported between the work of peer support specialists and those in more clinical positions such as case managers, counselors, and social

workers. Additionally, supervisors of study participants did not inform them about Americans with Disabilities Act protections due them as a person in recovery.

Lack of any required training for supervisors and agency leaders before employing peer support specialists could be a contributing factor. Supervisors and agency leaders need education on the role's occupational limits and in the unique needs and protected rights of individuals in recovery (Melemis, 2015; Hoge et al., 2014). Active and informed agency leadership is key to the implementation and sustainment of evidence-based interventions (Aarons et al., 2016).

However, Kentucky has no requirement for supervisors, nor agency leaders to participate in training before employing peer support workers. This may limit their understanding of the role and decrease its sustainability at the agency (Medoff et al., 2021; Aarons et al., 2016). Moreover, individuals working in any 1 of 20 roles may provide peer support supervision with no prior training required and with no guidance from the state such as identified core content areas. This overall lack of guidance may contribute to individuals providing less than adequate supervision, may increase role confusion, and decrease engagement of new peer support specialists (Gates et al., 2010; Gates et al., 2007).

For the above reasons, I *recommend* the state mandate supervisors, along with a representative from the agency's upper management, attend a training on the role and functions of a peer support before employing individuals in the role. Likewise, for organizations already employing these workers, the supervisor and an agency representative would have to attend this training. Agencies refusing to comply after two

warnings should lose the ability to bill Medicaid for peer support services for up to six months per violation.

Recommendation Six: Continued Education Agency Requirements

Ongoing development of these agency leaders and supervisors should continue after their initial training. Prior research demonstrated engagement in regular training opportunities can reinforce learning. In supervisors, it was a factor in them supplying high-quality supervision meeting the needs of individuals in recovery (SAMHSA, 2014).

I *recommend* the state require supervisors receive five hours of annual professional development and agency management representatives receive two hours annually. As an incentive for participation, the state should offer these individuals continuing education credit at no cost. Content should focus on growing the role of peer support specialists. State officials should enact regulations specifying these requirements and permit development of a standard curriculum covering peer support core functions for these learning opportunities. To ensure fidelity to the content, employees within the Kentucky Division of Behavioral Health should offer any supervisor and agency trainings.

Recommendation Seven: Revision of Supervision Requirements

Among study participants, I found a lack of consistent provision and use of evidence-based practices in supervision. Some individuals received only group supervision, though state regulations require individual sessions. Across the sample, there was an overall lack of consistency in the time agencies allocated for the activity. Times reported by participants ranged from the mandated minimum of two hours a

month to as high as two hours a week of supervision. Participants received several types of supervision. Some individuals received administrative supervision, while others engaged in the more effective clinical and developmental forms.

To allow adequate time for supervision, I *recommend* the state restrict individuals to supervising to no more than 10 peer support specialists at a time. The state should create a certified peer support supervisor designation for individuals in recovery from a mental health and/or substance use disorder and do not work in these clinical roles. Arkansas and Massachusetts have created an alternative certification program allowing individuals in recovery to provide peer support supervision. In July 2020, 10 peer support specialists became Arkansas's first peer support supervisors after they completed the state's peer supervision training.

In Kentucky, to ensure supervision is clinically and developmentally focused, rather than administrative, the state should limit other positions allowed to offer certified peer support supervision to individuals working as either (a) certified/licensed alcohol and drug counselors, (b) licensed social workers, (c) licensed counselors, (d) licensed psychologists, and (e) licensed therapists. These regulations should specify time in supervision must focus on core functions of peer support, including teaching, consulting, coaching, and mentoring/role modeling (SAMHSA, 2014).

Recommendation Eight: Ongoing Learning Opportunities for Peers

8a: Pre-Employment Training

For adults wanting to become a peer support, it may be the first time they are entering the workforce and/or they may be re-entering it after a considerable period

away due to incarceration or due to a stay in long-term residential treatment (Mental Health America, n. d.). They may need added support in transitioning back into the community and to succeed in the workplace (Green, 2019). However, there is no pre-employment training offered to individuals interested in becoming an adult peer support specialist in Kentucky. The state only requires those seeking certification as a family or youth peer support specialist to take part in the Kentucky Family Leadership Academy, a pre-requisite 15-hour training intended to advance leadership development among advocates (908 KAR 2:230).

In response to this identified gap, I recommend leaders in Kentucky's Division of Behavioral Health in partnership with persons with lived experience should create and offer a pre-certification training to individuals wanting to pursue adult peer support certification. In the training, participants would receive a refresher on expectations and skills for the workplace, hear what it means to be a peer support, and learn the steps in applying for certification. Individuals who need more support could participate in a paid peer support internship after the training, allowing them to further develop key competencies needed in peer support within a supportive workplace setting.

In creating such a program, Kentucky would follow the lead of other states' work in preparing individuals for the peer support role. Massachusetts requires individuals complete two trainings before applying for certification. One training, the REAL program, focuses on the skills needed to enter the workplace and on learning what being a peer support entails. Individuals participate in a six-week paid internship to further develop their confidence before applying for certification. The program has been

in place for the past two years and initial evaluation results showed it was effective in preparing individuals for their work as a peer support (Interview with REAL Program Director, 2021, June 23; Kiva Centers, 2020).

Kansas builds training and support into its stepped certification process. Individuals start at level one for up to a year, receiving ongoing supervision and training in the basics of peer support. They move on to level two, a certified peer support, after participating in more advanced training (Kansas Department for Aging and Disability Services, 2020). Minnesota goes even further, requiring level two applicants have 12,000 hours of direction supervision working with individuals having mental health disorders (Minnesota Department of Human Services, 2017).

8b: Increase Continuing Education Requirements

Investments in ongoing development can help individuals stay current in best practices for their field. It can increase job satisfaction and decrease turnover (Addiction Technology Transfer Center Network, 2017; Hoge et al., 2019; Israel et al., 2016). However, the state's website reports there are just six annual continuing education hours required for certified peer support workers. Kentucky's regulations do not specify what topics are to be covered in continuing education. I *recommend* the state increase continuing education requirement from six to ten hours. State officials should develop a list of approved trainings and trainers. Training content should focus on increasing peer support related knowledge and skills.

8c: Professional Development Through Communities of Practice

One way to cost-effectively increase professional development of peer support specialists and their supervisors is through communities of practice, one intended for the peer supports and the other for supervisors. A community of practice is an organized group of individuals coming together around their mutual interest or concern. To realize individual and group goals, members regularly engage in a process of collective learning through information sharing. By doing so, group members increase their knowledge and ability in addressing issues surrounding the shared domain of interest (CDC, 2019; Mandiberg & Gates, 2017; Wenger-Trayner, & Wenger-Trayner, 2015).

Prior research showed communities of practice were effective in the social integration of new peer support specialists and in increasing their empowerment. The model has proven useful in disseminating evidence-based practices to peer support workers and in increasing their use (Delman, 2014; Repper et al., 2014). Canada, along with Alabama, Massachusetts, Minnesota, New York, and Wisconsin, have developed communities of practice around peer support and supervision. Federal agencies such as the Centers for Disease Control and Prevention and SAMHSA, along with the national group, Mental Health America, have endorsed employing communities of practice for increasing knowledge and skills in a workforce.

In Kentucky, the Treatment Advisory Group (TAG) is an example of a successful community of practice. The group formed in 2017 and its mission is "…To bring together community leaders and addiction professionals to innovate and provide prevention and

treatment on demand for the greater health of those affected by the disease of addiction" (Rose, Email Communication, 2021, June 25). Through their Facebook group and monthly meetings, over 110 individuals working at agencies throughout the state come together discussing ideas and problem-solving issues around substance use disorders. During the COVID-19 pandemic meetings moved online and the monthly attendance increased. Staff from the Louisville Metro Department of Public Health and Wellness serve as facilitators for the group (Rose, Email Communication, 2021, June 25).

A similar program could sustain Kentucky's peer support workforce and increase the likelihood of individuals delivering high-quality services. Therefore, I *recommend* legislators enact regulations allowing development of, and annual funding for, a peer support community of practice and for a supervisor community of practice. Peer support specialists should lead creation of their community of practice, supervisors should do the same for theirs.

8d: Annual Peer Support Conference

Kentucky does not currently have an annual peer support conference which serves all peers. Previously, the state hosted the Creating Community Connections Conference. Conference attendees include supervisors and individuals supplying services such as targeted case management, peer support workers, and community support workers (Kentucky Cabinet for Health and Family Services, 2019). KYSTARS for Mental Health sponsors an annual peer support conference in Kentucky, with most presenters having a history of mental health disorders. This year's keynote speaker was a clinical psychologist and mental health advocate who did not self-identify as having

lived experience (KYSTARS for Mental Health, 2021). One group solely focused on mental health issues sponsored the conference and primarily highlighted mental health issues during it.

This approach to the conference served to divide the peer support community into two groups—those with mental health disorders and those with substance use disorders. However, there is no distinction made between the two in state regulations. Zero et al. (2021) found individuals with mental health disorders worked with clients with substance use disorders and the reverse was true. If the intent is for peer support specialists treat both groups, no matter their personal diagnosis, then a state-wide peer support conference should reflect this goal. However, the state lacks a conference which clearly serves individuals with mental health disorders *and* persons with substance use disorders.

I *recommend* the state partner with the members of the lived experience community around the state to develop an annual conference targeting all peers in Kentucky. This could help further develop a community of practice for peers. The state should ensure through regulation change sufficient funding to cover expenses. To ensure its affordability, cost of attendance should be $100 or less with scholarships available for individuals who could otherwise not attend.

Through peer support specialists coming together to share knowledge, there would be networking opportunities with peers from around the state. Participants could improve skills and service delivery through attending workshops on evidence-based topics important in peer support work. This conference could offer peer support

workers opportunities to learn from subject experts about innovative and promising practices and programs. Among the states, Alaska, California, Florida, Indiana, Massachusetts, Minnesota, North Carolina, Ohio, Oregon, Pennsylvania, Tennessee, Utah, Virginia, Washington State, West Virginia, and Wisconsin offer similar programs.

Conclusions

In this report, I have recommended changes in policy and practice to improve the certification of peer support specialists in Kentucky and to sustain their skill development once working in the behavioral health field. Briefly, these recommendations focused on:

1. Need for, and design of, a state-wide needs assessment of the peer support workforce.
2. Creating standards of practice and common code of ethics.
3. Adoption of a standard curriculum and examination for use by agencies providing certification training.
4. Mandating individuals must be in recovery from a mental health and/or substance use disorder for at least one year before applying for certification.
5. Requiring supervisors and agency representatives attend training on the role/functions of peer support.
6. Mandating supervisors and agency representatives receive annual continuing education focused on developing peer support specialists.
7. Amending regulations around the types and provision of supervision, (h) offering pre-certification training.

8. Revising regulations in the content and number of hours needed for peer support continuing education.
9. Increased professional development opportunities through creating communities of practice for peer support specialists and their supervisors.
10. Offering a state-wide annual peer support conference.

Through working with individuals having lived experience of mental health and/or substance use disorders to implement these recommendations in partnership with individuals having lived experience, Kentucky can ensure the readiness of its peer support specialist workforce. Making these changes can help ensure these workers are engaged, competent, and able to address challenges facing the behavioral health field now and in coming years.

CHAPTER SIX

CONCLUSIONS AND FUTURE RESEARCH

Mental health and substance use disorders are significant public health problems in the United States. Though federal and state government have spent billions to decrease the negative consequences from these disorders, we have seen little to no progress. A way to realize real change is through focusing on improving the skills and abilities of the behavioral health workforce.

Within the behavioral health workforce, those on its front lines typically spend the most time with clients. However, there is little time and resources spent to their professional development. Furthermore, there is little research examining the workforce development of peer support specialists. We lack understanding of the structure and delivery of training and supervision. As a result, there is little data available for us to use when working to improve the professional development of peer support workers.

Through the work of this dissertation, I contribute to our understanding of this issue within the context of the peer support workforce in Kentucky. The study's purpose was to qualitatively explore early career training and supervision experiences of 23 peer support specialists. All entered the field in the last three years and worked for

behavioral health treatment agencies located throughout Kentucky. Participants represented each region of the state.

Study Aims

The aims of my research were to:

1. Explore the transition from patient to peer support specialist as a social process during individuals' first three years of working in mental health and substance use disorder treatment.
2. Understand and describe effects from early career training and supervision experiences on peer support professional development.
3. Identify actions taken by these peer supports to fill perceived gaps in role related knowledge and skills.

Linkage Among the Three Manuscripts

The three manuscripts in the dissertation provided me with opportunities to understand the transition to becoming a peer support and key factors on their professional development. From this work, I made recommendations for improving policy and practice in professionally developing this workforce. Manuscript one, *'Developing a Professional Identity: A Grounded Theory Study of the Transformation from a Patient to a Peer Support Working in Behavioral Health Treatment'*, allowed me to obtain a big picture view of the problem. From this work, I identified the social process of transitioning from a patient in care to a peer support specialist working in the field.

Additionally, I connected how and why becoming a peer support can put an individual's personal recovery at risk. The Peer Support Professional Identity Development social process model was grounded in the data. Any claims made come directly from the perspectives and beliefs voiced by study participants. Participant quotes have been provided throughout this dissertation to support these claims.

The social process in manuscript one involved six distinct belief phases, including: a) *'where I need to be'*, b) *'the next day, you are in charge'*, c) *'consumed by the work'*, d) *'crossing that bridge of understanding'*, e) *'coming to terms with the work'*, and f) *'feeling like a professional'*. Study findings highlighted the significant adjustment period for participants when transitioning from a patient in treatment to a peer support working in the field. During this process, participants personal recovery was at-risk. It took time in their position before individuals set boundaries in their work and for them to seek support. They typically sought this support from their 12-step sponsor and were much less likely to share their struggles during supervision.

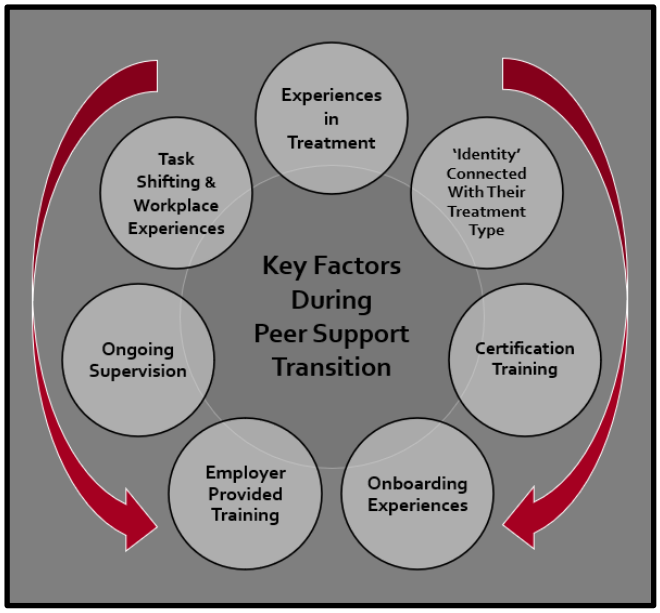
In manuscript two, *'A Qualitative Investigation of Peer Support Training and Supervision Experiences in the Behavioral Health Field'*, I explored effects from early career training and supervision experiences on peer support professional development. Overall, there was a lack of fidelity to best practices throughout training and supervision. In the manuscript, I identified actions taken by participants in filling perceived gaps in role related knowledge and skills. Without sufficient preparation for their role, individuals relied on subjective experiences and personal relationships in filling these knowledge and skill gaps.

Study findings showed a lack of standards in the training and supervision of the certified peer supports. For both activities, the content, methods, and time allocated varied from agency to agency. Participants reported a wide range of training and supervision experiences, with most perceiving knowledge and skills deficits in one or more areas relevant to their position.

Individuals employed various strategies in filling these gaps, including consulting with their 12-step sponsor, applying an approach learned in their own treatment, researching the issue on the internet, and bringing it up in supervision. Applying what I learned from the work of manuscripts one and two, I developed a conceptual model which frames the key factors during the transition from a patient to care to a peer support working in the field which influence professional development and their identity as an individual in recovery. See Figure 22 for a model of these key factors.

Figure 22

Key Factors During Peer Support Transition

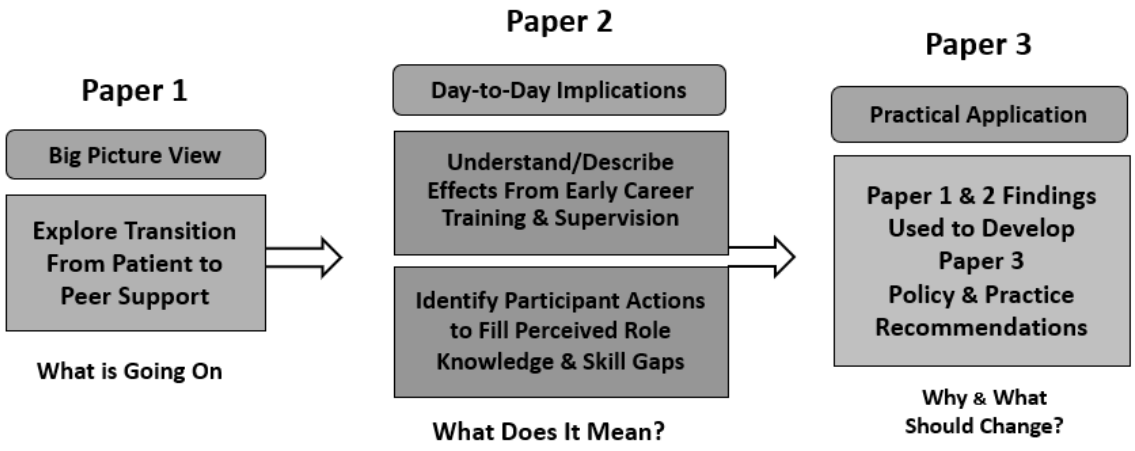


After developing this model, I wrote manuscript three, *'Policy Recommendations Stemming from a Qualitative Investigation into the Workforce Development Experiences of Early Career Certified Peer Support Specialists'*. In this policy paper, I discussed the implications of Kentucky's certification regulations, influences from model factors on transition process of becoming a peer support, and I described how changing practice and policy as outlined in the recommendations could further develop the skills and abilities of the certified peer support workforce in Kentucky.

Please see Figure 23 for a model of the links and connections between the three manuscripts.

Figure 23

Links and Connections Between Papers



Key Findings

Study findings pointed to an overall lack of adherence to accepted practices and evidence-based standards by organizations in Kentucky employing certified peer support specialists, including in: (a) fidelity to curriculum content; (b) delivery of certification training; (c) onboarding of new hires; and in the (d) supervision provided to certified peer support specialists. Training and supervision content, methods, and time allocated to each varied between the agencies.

Influences from an individual's personal model of treatment carried with them into their new peer support work. Most participants in this study went through 12-step treatment and needed time in the field before they could see the benefits of harm reduction and medication assisted treatment. They wished they had learned more about both in their certification and onboarding trainings.

Other study findings showed participants had a significant period of adjusting when transitioning into their peer support identity. During this time, they often became consumed by their work and put their personal recovery at-risk. They reported training and supervision was insufficient in preparing them for their new role. Only after participants had time in the field did they create role boundaries and seek needed support to protect their recovery, with this typically coming from individuals outside their workplace.

Most participants believed they had knowledge and skills deficits in one or more areas relevant to their position. To fill perceived gaps, participants employed a range of strategies, including consulting with their 12-step sponsor, applying an approach

learned in their own treatment, and researching the issue on the internet. They were least likely to bring up the issue in supervision.

Coming out of the interviews and from the review of job postings, it was also clear there was significant role confusion by agencies, with this trickling down to peer support specialists and their co-workers. Agencies often expected participants to preform duties outside of peer support's occupational boundaries. Shared experiences and understandings are at the heart of peer support work. However, when agencies require peer support workers to police the actions of clients and their families, this essential peerness may be lost. Losing this could lead to cooptation of the lived experience movement. Agency expectations around administrative and marketing duties were equally troubling and could cause a similar cooptation of the role.

Connections with Role Identity Theory

Study findings resemble Role Identity Theory as first proposed by George J. McCall and J. L. Simmons. In this study, a participant perceiving they belonged in the peer support role and were accepted by co-workers and supervisors was linked with their recovery identity. They could not transition into the role without their 'my recovery comes first' identity. There was a bidirectional relationship between the two identities.

Participants shared 'my recovery comes first' came from AA, their personal recovery came before family, work etc. They used this saying as a way of guiding what they did in their life. 'My recovery comes first' was their complementary identity

described by role identity theory. Like a parent identity depends on having a child, a study participant's peer support identity depended on them being a person in recovery.

When participants talked about losing 'my recovery comes first', they often brought up seeing certification training and onboarding training and supervision as insufficient. This meant their training and supervision did not cover issues like self-care, boundaries, secondary trauma, working with people having co-occurring disorders, medication assisted treatment, and harm reduction. They did not view supervision as a safe space for sharing their struggles and perceived gaps in knowledge. One participant described this as 'I didn't say anything because I didn't want my supervisor to think I couldn't do the job'.

In feeling unprepared for peer support role, a participant would doubt in their skills and abilities, if they could transition into becoming a peer support. These experiences increased stress levels and seemed to create a negative reinforcing loop. Experiencing this struggle resulted in them feeling they could not do the work. Not wanting to fail, participants would then work harder at 'belonging' in the role.

In trying to reach this state of belonging, participants talked of losing sight of 'my recovery comes first ' identity. When peer support specialists no longer focused on their 'my recovery comes first' identity-they felt out of touch and out of sorts. Participants described it as feeling like 'you know it when it happens, something just isn't right' 'it's that feeling- 'you get nervous' 'I know when I feel it- I'm anxious, I don't want to be around anyone' 'When it happens, I get angry easily over nothing'.

It was then participants would work even harder to become a peer support, thinking this was what was missing. Participants believed if they worked hard enough, it would eventually just come to them, that they would figure it out eventually. Working to the point they are 'consumed by the work' then puts them farther away from their 'my recovery comes first' identity. This looks like the time participants would describe feeling their personal recovery was at-risk due to the demands from their peer support role.

Breaking out of this loop happened when participants would 'cross that bridge of understanding'. They often related this experience to what they read in the Big Book. They realized 'I can't be everything to everyone' and if 'I'm not right, nothing goes right' and 'I had to get burned to learn'. When the peer support specialists broke this negative reinforcement loop, they were able to successfully take on their new peer support identity and incorporate it into 'my recovery comes first' identity. They could be both a person in recovery and a peer support.

At this stage, incorporating peer support identity into their life meant they reprioritized my recovery comes first. Actions taken at this time usually meant reaching out for social support, typically to their 12-step sponsor. They also created boundaries in their peer support role, so they could prioritize self/own recovery. In the coming section, I outline how these findings relate to the Big Book of Alcoholics Anonymous. Nearly every participant in the study relied on it to guide their thinking and actions, both personally and professionally.

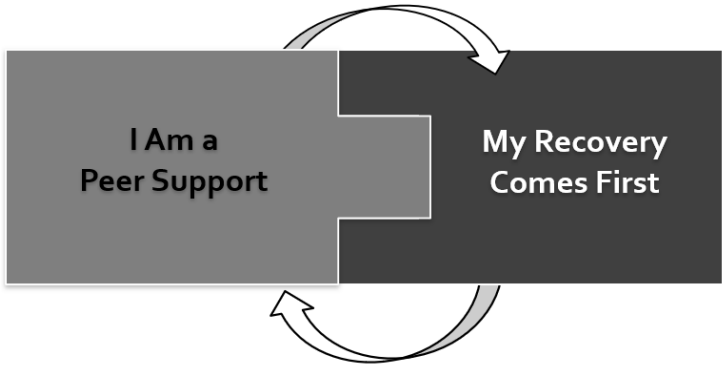
For example, this relates back to text in the Big Book of AA which states:

- Answers will come if your house is in order, but you can't transmit something you don't have.
- 'Great Fact' in the Big Book- When you gain/regain trust in God/self, results in simultaneously feeling accepted as peer support and capable of prioritizing 'my recovery comes first'.
- When your relationship with God/self is right—Great things will come to pass for you and others. In the context of this study, it means they feel capable of doing the work of a peer support.

At this point in this process, study participants created a new loop, both supportive of their life in recovery and their work. As they continued in the peer support role, it seemed to serve as positive reinforcement for their personal and professional life.

Figure 24

Correspondence Between Role Identities



Implications

Throughout the work of this dissertation, I presented recommendations for improving practice and policy for certified peer support specialists in Kentucky, these included:

1. Development and implementation of a structured peer to peer support system for individuals when entering the field as a peer support.
2. Rationale for the state to create and mandate use of a core curriculum standardized for peer support certification training.
3. Need for state-wide adoption of a structured onboarding for new peer support hires.
4. Increase use evidence-based practices during supervision through a state sponsored training for all peer support supervisors.
5. Decrease role confusion through the state developing and training agency administrators, leaders, and supervisors in the role of peer support within the behavioral health field.
6. Amend regulations to require continuing education for agency administrators, leaders, and supervisors that focuses peer support role development.
7. Increase professional development opportunities through creating communities of practice for peer support specialists and their supervisions and through offering an annual state-wide peer support conference.

Contribution to the Field

There is little research on the transition of individuals from a patient in care to becoming a peer support working in the behavioral health field. Through my work examining this issue, I developed a conceptual model of key factors and how these influence individuals during this transition. Through this model, I named practice and policy changes needed to support individuals during the transition and grow the workforce professionally. Through realizing these changes, we can improve peer support specialists' service delivery and potentially improve client outcomes.

Limitations

The present study is susceptible to various limitations. First, I chose to use qualitative methods in my research. Findings are not generalizable to the population level; they relate to the situation and context in which I collected data. Second, participants were essential workers during the COVID-19 pandemic. When asked to reflect in their interviews on past job stresses, increased workplace demands associated with the pandemic may have unknowingly influenced responses.

Third, the present study is subject to recall bias. In the interviews, I asked participants to retrospectively describe prior experiences influencing their professional development. Fourth, this study focused on understanding the certified peer support specialists' training and supervision experiences and the effects from these on their professional development. Their supervisors may have quite different perceptions of these experiences than the ones expressed by study participants.

Recommendations for Future Research

One avenue of future research that researchers should consider exploring is examining what happens when individuals cannot incorporate their 'my recovery comes first' identity with becoming a peer support. We should work to understand what was different in their experiences compared to individuals who succeeded in making this transition. We should look at how and why these differences played a role in the process. Researchers should identify what individuals perceived as making it difficult to transition into the peer support role. Researchers should seek to understand how this affected personal recovery. We should compare these experiences for individuals going through 12-step based, abstinence only treatment with those who went through a more clinical type of treatment that included use of medication assisted treatment.

Additionally, this study focused on understanding Kentucky certified peer support specialists' perceptions of their training and supervision and how these experiences shaped becoming a peer support and their professional development. Future work should examine this issue from the viewpoint of supervisors, as well conduct a comparative analysis between the two groups. Because regulations governing certified and registered peer support specialists in Kentucky are quite different, researchers should work to understand differences between the two in the professional development process and how each impacts job satisfaction and turnover rates between the two groups.

Researchers should conduct a comparative analysis, examining differences between the professional development of peer support specialists working in surrounding states. Indiana, Ohio, and Tennessee provide more structured and standardized process in certification training and supervision to their peer support to their peer support workforce. Moving forward, researchers should compare the skills of peer support specialists in each of the four states in delivering care and the effects from their services on client outcomes. Through future research into these areas, we can further refine the professional development of the peer support workforce.

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APPENDIX A

INTERVIEW GUIDE

1. Can you tell me how you define substance use disorders?
2. Probe: How did you develop this definition?
3. Can you tell me about your work as a certified peer support specialist?
4. Probe: How long have you have worked in the role? Where have you worked and what positions have you held?
5. Why did you first choose to work in this field?
6. Why do you continue working in this field?
7. What was your certification training like?
8. Probe: Where did you take it, how was it structured, and what did it cover?
9. Probe: What was missing/what was useful? How did this experience impact your approach to treatment?
10. Probe: If you feel there were gaps in your training, what did you do to fill these?
11. What have been your workplace training experiences?
12. How have these training experiences changed over time in the field?
13. Probe: What was missing/what was useful? How did these impact your approach to treatment?
14. Probe: If you feel there were gaps in your training, what did you do to fill these?
15. What have been your supervision experiences and how have these changed over time?
16. Probe: What was missing/what was useful? How did these impact your approach to treatment?
17. When/how did you feel supported in training?
18. When/how did you feel supported during supervision?

19. Probe: How did these experiences impact your confidence in providing care, in your approach/s to treatment?
20. When/how did you not feel supported in training?
21. When/how did you not feel supported in supervision?
22. Probe: How did these experiences impact your confidence in providing care, in your approach/s to treatment?
23. What do you share during supervision and why?
24. If you are unsure of how to handle a situation at work, who do you go to for help?
25. Probe: Why do you go to them?
26. What is something else that I should know?

APPENDIX B

Demographic Questionnaire Survey

1. Age in years: _____ Martial Status _____

2. How would you describe your race: _____

4. How would you describe your ethnicity: _____

5. What gender do you most identify most with? _____

6. What is the highest educational level you completed? *(Please select one)*

____ High School/GED

____ Some College

____ Associate Degree

____ Bachelor's Degree

____ Master's Degree

____ Doctoral Degree

7. Total number of years working as a peer support? _____

8. What is your employment status? *(Please select one)*

____ Full time

____ Part time

____ Retired

____ Other *(please specify)* _____

9. What is your yearly income? *(Please select one)*

____ Less than $20,000

____ $20,000 to $25,000

____ $25,001 to $30,000

____ $30,001 to $35,000

____ $35,001 to $40,000

____ $40,001 to $45,000

____ $45,001 to $50,000

____ $50,001 to $55,000

____ $55,001 to $60,000

____ $65,001 to $70,000

____ More than $70,000

CURRICULUM VITAE

Diane M. Zero

5916 Centerwood Drive
Crestwood, KY 40014
(E): dianezero@outlook.com (P): 502-445-1991

SUMMARY OF QUALIFICATIONS

- Over 15 years of nonprofit management experience, strengths include strategic planning, supervision of program staff, & donor/community relations.
- Skilled in project management, including Medicaid program compliance for service reimbursement, budget oversight, & maximizing resources through successful business & community partnerships.
- Proficient in grant development, management, & compliance at the foundation & state/federal government levels.

ACADEMIC PREPARATION

Doctor of Philosophy, University of Louisville *2021*
Specialization in Health Promotion & Behavioral Sciences

Master of Education, Salisbury University *1997*
Concentrations in Elementary Education & Reading

Bachelor of Arts, Virginia Commonwealth University *1992*
Dual Degree in Political Science/Philosophy

PROFESSIONAL EXPERIENCE

Health & Social Justice Scholar *August 2018-July 2021*
University of Louisville - Louisville, Kentucky

- Designed & managed 12-month user experience research project to assess needed changes to practice for a rural syringe service program.
- Developed & implemented 12-month research project to identify stigmatizing beliefs & behaviors of rural community members towards people who inject drugs.
- Created anti-stigma campaign for use by a rural district health department serving a six-county area in Kentucky.

Graduate Research Assistant *August 2017-July 2021*

University of Louisville - Louisville, KY

- Project Manager for an in-patient nurse training program to reduce stigmatizing beliefs towards patients with substance use disorders at Norton Hospital Downtown, duties included:
  - Creation of provider training vodcast modules & accompanying materials.
  - Assisted in development & management of project's evaluation component.
  - Management of funder reporting & participant recruitment.

Project Director *September 2015–June 2017*

Council on Developmental Disabilities/Lee Specialty Clinic - Louisville, KY

- Served as Project Director for a two-year grant partnership project between the Council on Developmental Disabilities & Lee Specialty Clinic to offer supported decision making in the healthcare setting to adults with intellectual/developmental disabilities.
- Responsible for management of all aspects of the project's evaluation process, creation of the training program for patients/providers & design of the project's collaboration activities.
- Developed successfully funded project grant proposals.
- Designed all project marketing & outreach materials, including provider-patient interaction videos.

Non-Profit Consultant *January 2013–September 2015*

Oak Tree Nonprofit Group - Louisville, KY

- Creation of budget monitoring processes, funding proposals, grant reporting, & close-out activities.
- Designed, implemented, & managed fundraising activities for local organizations; work included:
  - Development of annual giving ask, endowment support, & capital campaign materials.
  - Trained leadership, board members, & staff on fundraising, advocacy, & capacity building.

Executive Director *November 2000–December 2012*

School Scholarships - Louisville, KY

- Responsible for oversight of scholarship recipients' activities at 52 schools in Louisville Metro Area.
- Designed & managed effective evaluation program, tracking academic progress over seven-year span for participants.
- Leveraged program funding through developing strong partnerships with businesses, faith based, & community organizations.

- Wrote successfully funded grant proposals at the corporate, local, state, & federal levels.
- Developed strategic plans for the organization, worked with the board to evaluate progress on short-&-long-term goals, along with implementation of needed changes.
- Established the Family Education program, serving over 1,200 families over a six-year period.
- Effectively management of yearly program & fundraising events, raised over $5 million while at agency.
- Responsible for organization's marketing & outreach activities, scope of work included: Annual reports, donor outreach materials, community presentations, & social media presence.

Campus Administrator *June 1998–November 2000*

Youth Advocate Program- Lexington, IN

- Licensed Passage House Youth Shelter, a residential facility for at-risk youth.
- Oversight of a six-member executive management team.
- Responsible for all grant proposal submissions; including research, preparation, & reporting for funded grants.
- Ensured initial & ongoing compliance, with federal/state regulations governing out of home placements in residential care settings, & for Medicaid service reimbursement.
- Directed & coordinated all campus programming with program supervisors.

Director of Education *June 1997–June 1998*

Salvation Army- Salisbury, MD

- Hired as full-time employee after completing AmeriCorps service year.
- Hired & supervised the department's eleven-member staff working in four Learning Center sites.
- Trained & supervised over 50 Education/Social Work Department students each semester, for work with at-risk youth.
- Prepared successfully funded grant proposals at state & federal level, including:
    - Corporation for National Service, Program of National Significance Grant
    - Department of Juvenile Justice, Facilities Capital Grant
- As part of three-member team, drafted Maryland State Bond Bill #778, along with the bill's accompanying proposal package.

AmeriCorps *June 1996–June 1997*
Salvation Army- Salisbury, MD

- Established the Salvation Army's Education Department & Learning Center programming for at-risk children.
- Developed evaluation program to track academic progress for all participants.
- Developed partnerships with community organizations, including Eastern Shore Retired Senior Volunteer Program & Salisbury Chamber of Commerce.
- Recruited & trained over 30 community volunteers, then supervised their work in the Learning Center.

PRESENTATIONS

Zero, D. (2021). 'Chasing the Money': Unintended Consequences of Medicaid Reimbursement on the Personal Recovery of Peer Support Specialists working in the Substance Use Disorder Treatment Field. 17th International Congress of Qualitative Inquiry. Oral Presentation (Virtual). June 2021.

Zero, D. (2021). Developing a Professional Identity: A Grounded Theory Study of the Patient to Peer Support Transformation Process. Kentucky Public Health Association Creating Healthy, Resilient Communities Conference. Poster Presentation (Virtual). April 2021.

Zero, D. (2020). Decreasing Stigma Towards Syringe Service Program Clients in a Rural County in Kentucky. Society for the Study of Addiction Symposium (United Kingdom). Oral Presentation (Virtual). November 2020.

Zero, D. & Harris, L. M. (2020). Why Practice Transformations Occur in Substance Use Disorder Providers New to the Field: Implications for Abstinence Only Training Methods. American Public Health Association Annual Meeting. Poster Presentation (Virtual). October 2020.

Zero, D. & LaJoie, S. (2020). Reducing the Stigmatizing Beliefs of In-Patient Nurses Towards Patients with Substance Use Disorders: Pilot Evaluation of a Blended Learning Program. American Public Health Association Annual Meeting. Oral Presentation (Virtual). October 2020.

Zero, D. (2020). Understanding Transformations in Treatment Provider Beliefs Systems & Approaches to Practice. Graduate Student Regional Research Conference. Graduate Student Council. Louisville, KY. February 2020.

Zero, D. & Harris, L. M. (2019). An Evolving Meaning of 'Recovery': Understanding Changes in Belief Systems For Substance Use Disorder Treatment Providers Working in Louisville, Kentucky. 15th International Congress of Qualitative Inquiry. Champaign, IL. May 2020.

Zero, D. (2019). Recognizing Quality Treatment: Development & Dissemination of a Guide to Quality Treatment for Individuals with Substance Use Disorders & their Families. Health & Social Justice Proposal Presentation to the Academic Community. Louisville, KY. April 2019.

ASSESSMENT REPORTS & RESEARCH BRIEFS

Zero, D. (2020). A Multi-Method Assessment for Use in the Design of a Community Anti-Stigma Campaign. Submitted Lincoln Trail District Health Department. Bardstown, KY. October 2020.

Buchino, S., Fosl, C., Haynes, L., Kinahan, K., Omer, L., & **Zero, D.** (2019). Solving Street Homelessness in Louisville, Kentucky: Improving the Climate of Care for Individuals Experiencing Homelessness. Submitted to the Louisville Metro Council. Louisville, KY. June 2019.

Buchino, S., Fosl, C., Haynes, L., Kinahan, K., **Zero, D.,** & Beard, J. (2019). A Preliminary Assessment for Solving Street Homelessness: Applying Best Practices to Louisville's Continuum of Care. Submitted to the Louisville Metro Council. Louisville, KY. March 2019.

CURRENT SERVICE

American Public Health Association Policy Subcommittee, Member	*2020–Present*
American Public Health Association, Abstract Reviewer	*2020–Present*
Lincoln Trail District Harm Reduction Advisory Board, Member	*2020–Present*
Louisville Opioid Response Plan Treatment Metrics Goal, Co-Facilitator	*2018–Present*