

Establishing Peer Support Services for Overdose Response: Strategies from the Field Q&A Handout

Presenters:

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General Questions

(Re: involving people with lived and living experience in planning and implementation efforts)

How would a peer that is still using substances be beneficial to someone that is trying to stop using substances?

Zach: It depends on the type of services that the peer is providing. If it's a peer who's distributing safer use supplies and syringes or doing street-based naloxone distribution and overdose prevention education, the experience and knowledge of someone who is currently using in a community could be invaluable. If someone is trying to stop using all substances, they would probably benefit more from a peer specialist who has achieved positive improvements in their life after having made changes to their substance use behaviors. Peers are effective because they leverage shared experience. Which parts of their shared experience they leverage may differ based upon the needs and goals of the person receiving services.

How much of these peer recovery structures could be developed/utilized for people who are using drugs who are under 18? How hard is it for pediatric health systems to build these structures, both for adolescents and for caregivers of pediatric patients?

Nicole: In my limited experience in partnering with CHOP to provide some of these services for families, seemingly the role of the peer is unfamiliar, so it was hard to find a place for the peer "to live." Meaning there wouldn't be a network for the peer, sustainability of the role was confusing, and it was unclear who would provide supervision. As we build the model at CHOP, please feel free to reach out and get connected with us. Boston Children's Hospital has a model for [adolescent addiction medicine](#).

In PA, there is a training specific to providing services for youth. It is an enhancement to the core curriculum for certified recovery specialists. It may be something to look into in your state.

What efforts are being made to bring fentanyl test strips to the public and at-risk populations?

Nicole: In Philadelphia, the Public Health Department has a robust [fentanyl test strip initiative](#). I just collaborated with Jefferson (local health system) to do an instructional video (still in editing) to ensure they are being used efficiently. Personally, I carry them around to ensure people have them. [NEXT Distro](#) will discretely send them to those that ask.

Zach: This varies widely from state to state and jurisdiction to jurisdiction. Some areas are actively promoting distribution of FTS to PWUD. Some are fighting to do so but prevented from it by political pressures. Others are moving to prioritize other tools and placing less emphasis on FTS. It's important to

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recognize that FTS are a tool for engagement and not useful for helping someone quantify their risk. They're qualitative, and in a world where fentanyl is assumed to be present in most drug samples among opioid users, they may not provide new information to many people who use them.

How do you get reimbursement from health plans for services provided by peers?

Zach: This varies state to state and within states may vary from insurer to insurer. In Maryland, it is being piloted but only among Medicaid MCOs.

We have run into issues with legal, where they do not want us to ask, "Do you identify as someone with lived experience?", or list in the job qualifications that they must be a person that identifies as having lived experience. Any experience navigating this?

Zach: Sometimes there are "preferred qualifications" on job posting templates that can be utilized to encourage people with the skills and experiences you're looking for to apply, but that aren't then used as evaluative criteria on which job selection is made. Consider asking partners that work with people with lived experience to spread the word about the job for you and encourage people they know to apply. They may drive candidates to the application for you. Also consider proxy questions in job interviews like "Tell us what you know about trends in substance use in our community?", "What does lived experience mean to you?", or "What strategies are most effective for engaging PWUD? How do you know this?". If someone has lived experience and is comfortable sharing it, they'll often bring it up in response to questions like these without being directly prompted.

How do you deal with the conflict of providing peer services (that are voluntary in nature) in an involuntary setting, like the justice system?

Zach: I simply don't do it. In my programs, we'll take referrals and work together to connect someone who is involved in the criminal justice system in other services, but we do not actively collaborate to do so. Other parts of my agency do participate in such programs, like Drug Court, which prescribe treatment as an alternative to incarceration, but our harm reduction programs will not participate in these efforts on principle. We are involved with a local LEAD (Law Enforcement Assisted Diversion) program, and are more comfortable with it because participants in the program are fully supported to set their own goals and minimum requirement for diversion of charges is to meet one time with a case manager. The program also prioritizes "social referrals" which connects individuals identified as more likely to encounter law enforcement due to unmet behavioral health needs with services PRIOR TO law enforcement involvement.

Nicole: Supporting Your Peer Staff

How often do peers meet with clients/patients?

This is very patient/program specific. My personal practice is to meet the patient as many times as they need, both in the community and throughout the health system. Many programs are set up in a way that they bill per encounter, so they have policies around encounter quantity/length.

What primary topics or competencies would you suggest for Peer Support Specialists for ongoing training and professional development?

It depends on the milieu. In an acute care setting, it is extremely valuable to have access to trainings that provide guidance about evidence-based treatment options like MOUD. Personal bias trainings have

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also been valuable. Sometimes there is stigma around medication for opioid use disorder amongst the recovery community, even though it is the only evidence-based treatment for OUD, so the personal bias trainings have addressed some of that. Stigma trainings, harm reduction, motivational interviewing, then acute care setting-specific (e.g., how to navigate a health system, etc.).

Zach: Establishing PSS for Overdose Response at a Local Health Department

(Slide 52) For the overdose survivor outreach program: Do you get individual-level overdose information from ambulance partners? Are they able to share PHI? Wondering how you compile your list.

We get reports pulled from a state system by local EMS representatives. Local data sharing agreements support this. We also get the same reports in a more comprehensive fashion through a statewide system which pulls from both hospital and EMS reports. In Maryland, we are lucky to have state-level support for these reporting systems and coordination at the state level to feed that data back down to local public health entities for use in the field.

(Slide 53) What do you mean by "crisis system"?

For us, this encompasses a mobile crisis team and a local outpatient ambulatory behavioral health facility (called a crisis center) operated by our local hospitals. This outpatient center serves to divert from the Emergency Department and to engage individuals in services sooner, before they experience a mental health crisis, which requires an Emergency Petition. The mobile crisis team and the crisis center both employ peers. The crisis center peers work with patients who present for in-person services. The mobile crisis peers deploy with mental health specialists on community-based crisis calls and follow up on overdoses which are responded to only by EMS, specifically those who did not agree to hospital transport.

At Harford County Health Department, what role do peer support services have in targeted case management?

We have a number of targeted case management services. None are provided directly by peers, but when an individual receiving targeted case management services demonstrates a need for peer services, the case manager may offer it and introduce the person directly to a peer or make a formal referral. Depending upon the needs and desires of the client, the peer and case manager may continue ongoing collaboration, or the client may receive each service completely independently of the other.

How did the other organization get the syringe services approved in your area? How did you start a collaboration with law enforcement?

The other organization was Voices of Hope. Due to the political sensitivity of the approval, I can't share specifics, but I'd be happy to connect and strategize with other jurisdictions struggling to get approval in a one-on-one capacity.