The Role of Technology in Peer Supports

Announcer:	Welcome, and thank you for listening to this recording, part of the Comprehensive Opioid, Stimulant, and Substance Abuse Program (or "COSSAP") podcast series. COSSAP provides financial and technical assistance to states and units of local and Indian tribal governments to plan, develop, and implement comprehensive efforts to identify, respond to, treat, and support those impacted by the substance abuse epidemic. Since 2017, BJA has supported innovative work by COSSAP sites and demonstration projects across the nation.
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Sade Richardson:	Welcome. You are listening to "The Power of Peers," a podcast produced by the Peer Recovery Support Services Training and Technical Assistance Center, a project funded by the Bureau of Justice Assistance Comprehensive Opioid, Stimulant, and Substance Abuse Program, or COSSAP. The center is staffed by Altarum, a nonprofit organization that creates solutions to advance health among vulnerable and publicly insured populations.

I'm your host, Sade Richardson. Welcome to this podcast series that focuses on peer recovery supports. The Peer Recovery Support Services Training and Technical Assistance Center supports COSSAP grantees as they plan, implement, and evaluate Peer Recovery Support Services. The TTA center also provides support to non-grantee jurisdictions and organizations that are working to integrate peer recovery support services into public safety, criminal justice, or child welfare settings.

Stay-at-home and social distancing orders have changed how peer recovery support programs are supporting participants during their most vulnerable moments. Some programs have extended and enhanced their existing technology-assisted peer support to continue making personal and timely connections.

In this podcast, we profile three peer recovery support services programs in different organizational settings to learn how their programming has changed in response to COVID-19 and the role technology has played in their programs before entering the pandemic. In our first segment, we hear from Wendy Jones, Executive Director of Minnesota Recovery Connection.

Wendy Jones: We're a grassroots community-based organization that our mission is to strengthen the recovery community. And we do that primarily through peer-to-peer support services.

We also do a lot of public education and advocacy for the recovery community, and, specifically for peer support services, everything from telephone recovery support. So we have a program where

people sign up to get a call from us once a week, just to check in on recovery. During the era of COVID-19, those check-ins have become really, really long conversations.

We also provide one-to-one peer coaching over an extended period of time for anyone who needs it. We have a couple of special projects where we are part of a mobile substance use disorder support team that works in crisis centers in St. Paul. And we're also part of a team that's called Beyond Backgrounds that helps folks find housing, individuals who make a little more money than housing credits would allow for, but still have barriers such as bad credit or felonies on their records.

So we work with an organization that helps them find housing, and then we provide peer support as part of that. And then, we also do just kind of general recovery navigation for folks. We get a lot of calls from people who are just needing, you know, to help navigate the system. And so we do extensive peer support that way. So that's just kind of a big overview of many of the different types of peer support that we provide.

Sade:	How do you typically use technology to support your program?
Wendy:	So the old-fashioned phone—that's the heart of a lot of the technology. And that, you know, has increased exponentially during the pandemic. So both people calling in and us calling out for our projects like the Mobile Substance Use Disorder Support and the Beyond Background Housing Program; we do end up communicating with people a lot through text message, providing peer support that

way. That seems to be a method that people are really comfortable with.

And then we've converted many of our group meetings to Zoom. So we provide All-Recovery meetings, which, you know, honor all pathways to recovery, and with the advent of COVID-19, we converted all of those to Zoom. And what that did is, it also enabled us to offer meetings at times that we normally wouldn't, just because it's hard to get people physically to a certain place at a certain time.

So we have one now at 7 o'clock in the morning that has actually been very popular. So it seems to be a really nice fit to use technology in that way. So nothing, you know, extraordinarily sophisticated—we do not have a mobile app or anything like that. Although we're aware of some partner organizations that do have a recovery app, but our main sources are Zoom, the phone, text messaging, and then we do have extensive online resources for people.

Sade: You mentioned using text-based support. Can you talk a little bit more about that work?

Wendy: Sure. We're hoping to be able to expand that to our telephone support someday to offer kind of more general texting support. The phone system that we have isn't quite ready for that, but they will be adding that tech support soon. And that's having a number that is not a personal cell phone so that our peer recovery specialists don't have to use their, their personal cell phones for text support. But, on a limited basis, we are able to do that through Google Voice, and to give our, our peers a third-party number to use to be able to provide that

texting support throughout the day when a peer is working. And sometimes, individuals needing support aren't necessarily in a situation where they can make a phone call, but they can send off a text, and just even getting that quick text in response to let them know that we're here for you, and someone is checking in on you—that can make a huge difference. So it's just meeting people where they're at. And for some folks, texting is the most convenient or appropriate method for having an exchange or just reaching out to connect with somebody.

I should say that we also have a pretty large social media presence, and if you're looking at all sorts of technology platforms, that we provide essentially peer support through our social media, really promoting positive stories of recovery and modeling hope and sharing stories of recovery. We do a Tuesday Gratitude live post on Facebook. It's a watch party, essentially, on Facebook that always generates a lot of participation. And then we have a fair amount of recovery support activities through all of those social media channels, through Facebook, Twitter, Instagram, LinkedIn.

Sade: Social media—was that something you were doing before the global pandemic, or is it something that you're now more engaged in because of the current climate?

Wendy: We were doing that before, and we've seen somewhat of an uptick on that. People will often message us through social media, seeking support. So I do have people assigned to monitoring that. It's really important to get back to people quickly. So I don't think that that has,

we're doing quite a bit of that before COVID-19, and I think this is being used a little bit more and we've stepped up a little bit, but it has not drastically changed since then.

Sade: Have you seen any major changes with your service provision?

Wendy: Yeah, particularly in the Telephone Recovery Support Program. And this is a program again where people sign up to get a call. It's not a warm line. It's not, you know, people calling in, but it's that knowing that once a week, someone's going to call and check in with you and see if you want to talk.

So we, we had just a huge uptick in people signing up for that, with the launch of COVID-19, I'd say, like a 50 percent increase during the first month or so of, of COVID-19. The other change that we've seen is that, you know, previously, a lot of folks might not pick up, you know, it's, it's sometimes, you know, just if someone's calling that's all you really need. Or, if they did pick up, it might be a brief conversation like, "Oh yeah. You know, I'm doing okay. Thanks for checking in." Our peers who make those calls have said that, they're often now on 30-, 40-, 50-minute conversations with people. So the, the length of time has substantially increased. So we've seen a huge change there in that regular telephone support. The other change that we've seen—we've had about a 30 percent increase just in calls to the organization for recovery navigation. So that is anybody, you know, is calling in when, during our open hours, and our navigators field calls ranging from, you know, where to find sober housing to "I'm unemployed and need help

navigating the system," to someone who, as a family member who perhaps is experiencing substance use disorder stress.

So the navigators, they're kind of there to help field these calls. They don't always have answers, but they will help people find answers. And that service has really been impacted by the COVID-19 pandemic.

Sade: Are there guidelines that have been put in place to monitor peer burnout and help prevent that?

Wendy: We do have guidelines in place, and it's really about boundaries. We see that more in the mobile substance use disorder support team, where they are working with individuals who usually are in a higher state of crisis and it can be difficult for them to turn off their phones and to not be available for, for texts and calls. So that's, that's more where we see the, the burnout—not so much, with the telephone recovery support program. I think in general, the peers have been really anxious and eager to be able to help people during this, this time. But we do as a standard practice have, professional guidelines and boundaries in place to help protect the peers.

Sade: What sort of guidelines do you all currently have around technology use?

Wendy: We do not want people giving out their personal cell phone number. So we really need to create that boundary between when you're working and when you're just an individual in the community. And so that's a really important one. I think it's very, very easy in this work for your personal and your professional life to blur together, and that really contributes to burnout. It's a profession where you really want

to help people, but we've had to establish that firm boundary around "When you're working, you're using Minnesota Recovery Connections' phone number, or you're using the Google Voice number that we've assigned to you." And that's probably the biggest one. There are other, other best practices; we always want to be doing more of the listening and less of the talking, which can be hard to monitor sometimes, because you can't see people's facial expressions when you're on the phone. So there are reminders around how to engage people via technology and how to not dominate the conversation—like I'm doing right now. And then, we also had to establish some guidelines around Zoom calls, since it's really important that individuals share their video, allow any recording of Zoom calls. The reason that we have everyone share video is that if you're in a meeting, it's important to be engaged, and, and our All-Recovery meetings are really about the group listening to each other. And it's, it's very hard to demonstrate that if you, you don't have your video on. And then we've also had to restrict access to some of the Zoom calls just because we were Zoom-bombed several times when we first started offering All-Recovery meetings. We were a little too accessible with the Zoom link. So we've had to put some restrictions, and now the host has to admit people, and some other safety precautions in there.

Sade: Can you talk a little bit more about the virtual peer-led support groups, like how those work, how are they different or similar to the in-person?

Wendy:

The big difference is that you don't, can't have coffee and donuts unless you have it yourself at home. But, the Zoom, using the Zoom technology for that does enable the group to see each other. And we have a check-in sheet that we encourage people to download in advance, or to have open. And then, the moderator sort of just opens it up with some guidelines, and asks people to think a little bit about where they are with their recovery capital–that's just how we start an All-Recovery meeting, it's just kind of check in on, "How am I doing with my physical health or my financial health, my spiritual health?" You know, check in on recovery capital. And then we use that, that reflection time to start the conversation. So would anyone like to talk about why they are where they are on that scale? So we have people kind of rate themselves from 0 to 10 and that gives them, forces them to kind of think about and self-assess and then gives them a starting point to share.

And the moderator is also a member of the group and they're sharing. And no one has to share if they don't want to. And no one has to get feedback if they don't want to. So we always ask for permission, if you're open to feedback. And so it's very similar to the in-person experience. It's just that, the person facilitating the group has to be conscious of, you know, admitting people through Zoom, when you see that pop-up, has to be conscious of really paying attention to the different screens, to make sure that everyone is engaged. And that's a little harder to do through a screen than it is in person. And some of the things that we would have people just read a piece of paper to

reflect, we have to do more reading out loud to the group, but they've been remarkably successful.

And it's never going to replace that in-person experience, 'cause there is a certain level of energy and camaraderie that you get being in person, but it also has removed some barriers. So for example, the 7:00 a.m. one. People who wouldn't normally get up and drive or take public transportation to a 7:00 a.m. meeting before they go in to work can just do that from the comfort of their home. And then we've also pulled in folks from outside our immediate geographic region, from greater Minnesota, who don't have access to All-Recovery meetings in person, so they've been able to participate remotely.

Sade: What advice would you give to another organization that's thinking about using the technology or virtual support that you already implemented?

Wendy: Think about security, and it depends on the level of support that you're providing. If it is something like an All-Recovery meeting, it is not an individual, private experience—it doesn't fall under HIPAA compliance. But it's important to honor and respect the fact that some individuals may need some practice and not be as comfortable with the technology. So having a facilitator who can recognize the discomfort that that technology might provide some folks at first, I think is important. You know, being patient, going through things, explaining things. It's important to, have those boundaries for your, your staff, and not expect people to, use their personal phone numbers.

I should also add that because many of our staff have to use their cell phones—even if they are using a third-party number—that we do provide a stipend to them to offset the cost of their mobile phone contracts, because we're asking them to use a personal device in a work context. So I think that's important to budget for that, as well. And then, really, you have to promote and be clear with your, your audience. There's just a lot of handholding—we do a lot of marketing around Zoom meetings. We're working today, actually, on a little video to sort of help people understand, what is an All-Recovery meeting? How does that happen on Zoom? The more you can show people instead of telling them, I think is really helpful. Just be cognizant—it's a different tool, and you may have to implement some other security measures. You may have to compensate staff differently and you need your facilitators to really recognize that not everyone is as comfortable as others. And also, thinking about that etiquette, if you, if you're on a phone call or if you're in a Zoom call, you're going to miss some of those in-person cues that you might get. So how to stop, listen, check in, do that more overtly, instead. When you're in person and sometimes that just kind of happens more naturally, 'cause you can, you can see it or feel it in the room. I would just say that what we're learning is that it's good to have a mix of options for people. The COVID-19 pandemic has forced us to use more virtual tools and use more technology to connect people to Peer Recovery Support Services. I think it's important, though, that you always still keep other options, when you can, for people. We, we're

definitely going to keep some of the things that we've been doing, but we're also really looking forward to bringing back some of the in-person options as conditions change with the pandemic. So I would say more is better, more options for people to connect with Peer Recovery Support Services, and the technology probably should never fully replace an in-person experience.

Sade: In our second segment, we hear from Melissa Pierson, the deputy director with the Franklin County Office of Justice Program.

Melissa Pierson: We're a metropolitan regional planning unit—which doesn't mean a whole lot to a lot of people—but what essentially that means is we're a large enough urban area, that we can essentially bring a lot of funding straight to the local area, versus having to go through a state organization like the Ohio Office of Criminal Justice Services. So in terms of funding, we kind of have some advantages. We are able to seek our own funding through discretionary grants but also receive formula grants directly to our office.

In our role as a regional planning unit, we are responsible for criminal justice systemwide, strategic justice planning, and that can be anywhere along the intercept mapping model. So we are involved in anything in Intercept Zero, where we're looking at prevention efforts, diversion efforts, all the way through Intercept 4, where we're looking at reintegration back into the community. We dipped our toes into the peer-support realm as a result of a program that we launched inside our Franklin County Jail.

And to give you a little perspective, our jail has—had prior to COVID—had an average daily population of right around 1,900 to 2,000, so pretty large urban jail. And we had decided early on that we were going to focus on the female population, and more specifically, the female population that is assessed as medium- to high-risk, had multiple prior arrests, a mental health diagnosis. And in recent years, ladies who had also more than likely an opioid addiction, or some other co-occurring disorder. So by virtue of that program, which was largely pre-release, we'd start the program about 8 to 10 weeks prior to someone getting out of our local jail.

And then we would continue with post-release. We recognize that in order to really establish those relationships and that rapport to work with the peers that we hired, we wanted to bring them in and start introducing the participants to our peer supports. And we started with three peer support specialists, and they would come into the jail roughly about 70 percent of the way through the program, so about weeks 6 or 7 into the pre-release program. And we would introduce the participants to the peers. Something that's important to know is that our program is completely voluntary. We don't allow the court to order folks into the program; it is truly voluntary. So what we ask is if you want to be in our program, you've got to want to be law-abiding, obviously, and you have to be willing to work with us. Those really were the only two requirements. So by virtue of being in our program, you have the opportunity to be linked with a peer support specialist.

We've had to adapt how our peers work with clients as a result of COVID.

So pre-COVID, it was pretty robust in terms of, we were able to do a lot of face-to-face interaction. Because we hire our peer supports as independent contractors, they're then able to provide transportation services to a lot of our participants for treatment appointments, job interviews, basic needs, like getting them to the grocery store, things like that. Once somebody is released from the jail and they've been linked with the peer support specialists, we do require that they are willing to check in with a peer support specialist at least once a week. We know schedules are varied, so we, we try to be as open and try to provide as many mechanisms for contacting the peer as possible.

So a couple of things that we did—we launched a Saturday recovery management group, and that was in person. We located a space at a peer center, where our participants, who wanted to come together weekly and meet with their peer support, but even more than that, have that sisterhood of other participants that had graduated from the program.

This was a venue to offer that opportunity. So that was on Saturdays and there generally was a recovery management theme, but sometimes we just had fun. We would have a cooking lesson, or we'd have a financial planning lesson. We have the Ohio State University here, locally, that has dedicated, once a month, to doing art expression work. We find that our ladies, a lot of them have a lot of trauma in their backgrounds. If you were to look at their ACE scores,

we average anywhere between 6 and 9 on an ACE screening inventory. You're familiar with ACE—those are pretty high scores. So we found that arts expression is a really great way to allow the ladies to express themselves.

Maybe they don't know how to articulate it verbally, but through arts expression, they can express it in other formats. So we do arts expression once a month. We do field trips. So for those ladies that want to join us on Saturdays, that's something that we do. We also offer yoga, physical calisthenics. I'm a certified aerobics instructor. So I went in for four weeks. . .and a pound class on Saturdays, which is basically just getting your heart rate up, and you have drumsticks in your hand, and you, you have routines to music—that seemed to really go well with our ladies. But for those ladies that, say, work on Saturdays, peer support can also be in the form of just a weekly check-in by phone. We really try to emphasize open-ended questions to get the ladies talking about their situation. We also do lots of texting with our ladies. Of course, that's carried over to post-COVID. So just anything we can do to get the ladies engaged, to keep them engaged. We really try to foster a support system. And that's not just what the peers, but with the other participants, as well—a sisterhood, if you will. So that if a peer support specialist can't necessarily be there on a Saturday, it's something that the peers themselves could continue to do. We haven't had to have that happen, but we want it to be something that's ongoing and, and truly serves as a support system for everybody who's engaged. Post-COVID, we're trying to do a lot of the

same things, but we've really had to get a little bit more focused, because our in-person engagements are limited, and in fact, in some cases, have ceased altogether, just because of the just safety concerns. We've really had to, we've had to pivot our service delivery model, and what that means for peer support is we're having to engage a lot more by Zoom. Amidst all of the chaos, we have found some other ways to communicate with our participants, and Zoom has been an amazing for engaging with our participants.

So the Saturday recovery management groups now are not offered in person. They're actually offered virtually. And again, same premise that we still meet, and we have kind of a recovery management theme each week. 'Cause most of our ladies are in early recovery. That's really, really important. And something I keep telling my staff is, amid this coronavirus pandemic, we're still in the midst of the worst opioid epidemic I think our country's ever seen. Ohio is actually, unfortunately, ground zero for opioid-related overdoses, and COVID-19 has actually made that even worse.

And I think that's a big result of folks feeling socially isolated. A lot of the anxiety that's come along with this pandemic—it's really hit our target population extremely hard. So we've had to get very creative to make sure that we stay engaged with our participants. Our peers are kind of a unique group, because not only do they provide peer support services by virtue of having lived experiences themselves, but we really require them to offer case management supports as well. So not

only are they kind of offering that emotional support, but they're having to make sure that some of the basic needs are covered.

Just making sure that folks now are coming out of the jail with basic needs. Do they have access to food? Do they have stable housing? All of our peers are trained to be able to do a Medicaid benefits application. We are very fortunate that we are a Medicaid expansion state, so they are all trained to do that.

We have a dedicated person with our job and family services department that our peer supports can send over benefits applications, that's both for food and health, directly to that person, and we can have benefits turned on literally that same day, with a presumptive eligibility. Our peers make runs to the food pantries, and of course, they drop off—there's no, there's still that six-foot mandated social distancing, but they're able to drop off food. They're able to drop off other supports. I know that we've been dropping off masks, and we just ordered a thousand doses of antibacterial. We also are able to provide Narcan kits, fentanyl test strips. So even though we're not able to be face-to-face, in a lot of our engagement, we're still dropping stuff off in mailboxes, on porch steps, and things like that. COVID has forced our peers to really get very focused and really triage our cases, because telephone calls really only lasts for so long. We want to make sure that those phone calls are effective. So our staff are trained to get on a phone call, really focus on what does that individual need? We really try to focus on what that individual needs versus what we think they need. We try to work with everyone to

come out of jail with a transition plan. But again, that transition plan is focused on where they want to go, what their goals are, and not what we necessarily think is the best thing for them. That doesn't change just because of COVID. Unfortunately, because of COVID, though, we're not working in the jails. We have not actually been in the jail since March.

So that's made it a little more difficult. While we're still working with the ladies that came out pre-COVID, we want to make sure we're engaging with ladies that are being released. So it's added some layers of challenge, in that we're not able to establish some of that rapport and relationship building that we, we were able to do when the ladies were involved in an 8- to 10-week pre-release. Post-release now is, is very focused on making sure that basic needs are met, making sure that we are getting people linked to treatment. We are not treatment providers—I tell my staff that all the time—but making sure that people have linkage to treatment and to medication-assisted treatment services. Since we work with so many folks with opioids as their primary drug of choice.

And, of course, acknowledging that fentanyl is in everything, even if opiates aren't your drug of choice. We're seeing a lot of cocaine, a lot of meth resurgence, making sure that they're aware that fentanyl is in everything in Ohio. So just a lot of harm reduction. Education is being offered via Zoom, via telephone calls. Any, any mechanism—we can do it. I think one thing that we've done since COVID is we created an online Facebook, private group. And it truly is private. We have four

staff that are administrators to make sure that only those that have participated in Pathways are able to participate on our private Facebook page. We monitor it very closely. There's a set of rules that everyone who wants to engage by Facebook through this private page must adhere to. There's no profanity. There's no talking about previous drug use to make it sound glamorous and glorious, the "good old days."

None of that's allowed. It truly is a forum for ladies who want positive reinforcement, positive social engagement to come together, and just share that time. So we've really had to get creative. We send a lot more cards out in the mail highlighting milestones, like one-year recovery goals, getting a job, you know, anything we can do to engage.

We are using the telephone a lot. I know that there is a perception that, that a lot of folks who maybe are coming out of the jails or prisons don't have access to mobile technology. And that, obviously, in some cases is true. We found that our participants though, by and large, do have access at least to a mobile phone. And when they don't, we do link them to some of the government-provided opportunities for getting a telephone, getting Wi-Fi access. But that hasn't been the majority. I think that was a surprise for a lot of us. We were very worried about that. But that really hasn't created a huge barrier for a lot of our, our ladies. So using Zoom platform, we have access to all the office meetings platforms, but we pretty much relied on Zoom. I think it's pretty user-friendly. We were able to put in place some of

the privacy considerations, like the passwords, and things like that to make sure we don't have people Zoom bombing, things like that. We are using texts a lot. Something else I should make you aware of, that we've been able to purchase, something called EZTexting. And what that allows us to do is reach out to our entire distribution list. We're able to push out messages. Like this week, actually today, we have a Wednesday walk-in, and it's at a treatment center where folks can come, and they can get immediate access to assessments. They can get identification printed right there on-site. They can get a hot meal. They could get HIV, hepatitis testing, access to MAT services. So we want to make sure that information is being pushed out, right? So we have access to this EZTexting, which allows us to push out that kind of information. We push out inspirational messages, updates, meeting reschedules, things like that. So that's how we've used a lot of the technology.

I think we're going to keep learning as we go, to make sure that we're able to engage everyone, 'cause everyone's preference is a little bit different. But again, we're not clinical—we don't do telemedicine. But we certainly are taking advantage of all the lessons learned from some of those new ways of doing business that telemedicine is offering.

Sade: What guidelines have you put in place for peer specialist technology use?

Melissa: Well, privacy is probably our most talked-about subject. We want to make sure that we're always adhering to HIPAA and 42 CFR

consideration as it relates to sharing of public-private health information. We are not covered by HIPAA.

We are not a medical agency. We don't have access to diagnoses. But with that said, we still train our staff on HIPAA, on 42 CFR, making sure that we always have releases in place for any interactions with medical providers or treatment providers. Our staff probably is taught to err on the side of caution—we like to be risk averse.

So when there's any doubt about sharing of information, the protocols call is to check with supervisors first, and again, always err on the side of caution. As it relates to our Facebook group, as I've said, we've built in a lot of layers to make sure that information that shouldn't be shared isn't—we don't post photos on the Facebook page.

We think that's important not to do. We don't talk about other family members. We don't talk about people's diagnoses. We don't talk about treatments. We try to just keep it very much, I don't want to say lighthearted, but more, just inspirational, more support, positive supports, and that kind of thing.

Ethics are a big concern for us too—making sure that we're, we're setting boundaries, and that's whether you're in person with someone, or on the telephone, or on a Zoom meeting. So just making sure that you are adhering to the ethics that you adhere to by virtue of becoming a peer support specialist.

So I'd say those are the primary three that we're looking at is just using technology in a way that allows us real engagement, meaningful

engagement. But again, making sure that those boundaries are still in place, regardless.

Sade: What advice would you give to someone or an organization that's thinking about starting a program like yours?

Melissa: Sure. So I guess the biggest advice I would give is, you know, don't assume that your staff is always going to be technologically savvy. I mean, for me, a lot of this was a big learning curve. I think for some of our staff, getting used to scheduling a Zoom meeting, getting used to facilitating a Zoom meeting—you know, that takes practice, that takes learning.

So making sure that you, if your expectation is that your staff is going to be engaging, and you want that engagement, again, to be meaningful and as robust as it was prior to needing to do a lot of stuff virtually, make sure that you're offering educational opportunities to learn about Facebook, to learn about, you know, lessons learned, about where things can go wrong in terms of privacy sharing.

So I'd say education and training is number one. Number two, for me, it's always about staff. I heard this from a sheriff in Middlesex, Massachusetts. He said, you know what? You can operate a program on a shoestring budget and it can be the best program out there—really have meaningful impact. Conversely, you can have a program with a budget of millions of dollars, and it still might not be a great program. And that all comes down to staff. If you don't hire staff that believe in change, that believe that folks inherently are good, that

believe in giving people second chances, then you're not going to have a good program.

We've made a point to hire people that believe in second chances. In fact, most of our staff are folks that might have been criminal-justice involved themselves. Again, most of our peers also have some kind of lived experience, in terms of they're in recovery, and/or had had, or are in the midst of a mental health recovery themselves. So to me, staffing is just—that's the secret sauce. It's staffing that are passionate—passionate to the point that sometimes you have to reel them back, right? 'Cause you always have to worry about compassion fatigue. I think, during COVID times that's something that we have to be even more mindful of.

My staff, I think, gets very frustrated, because you're doing everything virtually and a lot of times you're not able to see body language. You're not able to see, maybe eyes that aren't looking forward and making eye contact. So you're missing out on some of those nonverbal cues that really tell you how a person is truly doing. So that can be frustrating. And, you know, we have to watch out for our staff thinking they need to be on call 24/7. And again, that comes down to boundaries, and that's up to management to really lay down those boundaries and make sure that staff adhere to them, and that's, that's to avoid compassion fatigue and burnout. Training, again, I can't emphasize that enough—making sure you're offering your staff training, even if it means virtual training. Most of our staff are going through mental health first aid training this week. Just because COVID

has prevented us from doing in-person, we're trying to engage them in virtual training as much as we possibly can. So I think those are the, those are the big pointers that I would give out right now.

Sade: In our third segment, we'll hear from Tiffany Lombardo, executive director for addiction services at the Butler County Mental Health and Services Board.

Tiffany Lombardo: We are the local—basically hub—for behavioral health services in our county. So we are basically the exclusive stewards of any public funds that come in for services in Butler County. And we support programs, we monitor services that are being provided, and we look for innovative ways to help meet the needs of our community and what the specific needs of our community are.

So we started taking an interest in peer support services about four years ago—I would say maybe almost five now. And really, we're looking at, you know, we were in the midst of, and you know, we really still are, in the midst of an addiction crisis. Opiates had really hit our community really hard.

We were in one of the, Ohio is one of the states with the highest death rates. We were one of the counties in Ohio with one of the highest death rates. So we really were looking at What can we do to make an impact? What are, you know, let's start thinking outside of the box, what are things we can do that really can, you know, hopefully make an impact and make some changes for the community and be making some differences?

So, that's when we really started looking at peer support. That was around that time is when the state of Ohio began looking at having a certification for peer recovery support specialists—it kind of dovetailed pretty nicely. We do have some unique programs, and then we also have programs that are more of the traditional, you know, kind of model of within treatment. But we really took the peer support model and were able to find ways to integrate it in areas where we felt there were gaps. So we have a peer supporter in our local jail who does outreach and works with inmates that have come into the jail and gets them connected to services for when they leave, gets them connected to resources. We actually do have treatment services in the jail; so if they're going to be there for a period of time, then she's able to get them connected to that. And we've seen a lot of great success in terms of being able to, just to connect people to resources they wouldn't have been aware of otherwise. And by them viewing her as a peer, it breaks down some of the barriers in them being willing to open up.

So it began then looking at How we can do some outreach following overdoses? We adopted what has become known as the Colerain Model for Quick Response Team. Colerain Township, Ohio, actually borders our county, so there was a lot of familiarity with Dan Malloy and the team in Colerain. We were really able to take that model and mold it to fit our community. We put what we call care coordinators, and these aren't your traditional peer supporters, they're not certified peer supporters in the state of Ohio. They are care coordinators, but

all of them have some type of connection and lived experience. One of them has lost her sister to overdose. One of them, you know, his mother was an addict. A couple of them are in recovery themselves. So we really find people that have a passion for the people they're working with and are willing to just go out into the community and do some amazing outreach, and get people connected to treatment when they're ready.

That program actually has been a partnership between our board and a faith-based nonprofit, as well as a private community partner. So, we kind of have shared funding and really have all come together to support that team and to support the growth of that program. We started out with one care coordinator in Butler County, and now we have four.

We've really been able to utilize that programming and get people into treatment and seen a lot of success there. And then, lastly, the more nontraditional way that we've used peer supporters—we actually started a program with one of our local emergency departments, and we have a full-time peer supporter in their emergency department.

They actually didn't start out at full-time. They started out, 'cause we weren't sure how much they would be utilized, so they started out just being on-call and then they moved to two full days. And now, the hospital actually helps fund that position to be there full-time.

So the hospital just saw the value in having that peer supporter there in the emergency department, where we're able to potentially catch

people and get them connected to services, give them some

education before it becomes too late, and that we're able to connect

with people and get them connected to treatment directly from the

hospital, in some cases. We've really been able to adapt that and

that's the model that has been, we've seen growing now through the

region.

Sade: How do you typically use technology to support your program?

Tiffany: So we do things a little differently in each of the areas, just depending

on what the needs of the program and the format is. So in the jail, it's

a little different. They utilize a lot of the existing jail systems for

following up on things. But one of the biggest things that we've used

is, we actually have a partnership with a platform called Core Data,

and they've really helped us build a platform where we can track and

refer and connect clients from the QRTs, the Quick Response Teams,

and really, collect some data and do some follow-up on them.

What's been really unique with that is, they're able to kind of supply

some things in real time and follow up with clients that are in the

system that have been touched somewhere else before by another

worker. So that we really can start to build that story of, who's been

contacted and what kind of contacts that they've had across the

county. That's probably been the most helpful in terms of follow-up

and data and tracking. And we're building a module for our ER peer

supporters to begin using that as well. I will say that our care

coordinators, the ones that are doing the significant amount of

outreach into the community—in terms of technology they've really

been using social media platforms to connect with people and follow up with people. So that's been a huge help. Because what we found is that, while the majority of people may have phones, they don't always have minutes on their phone. But, if they can get to a Wi-Fi area, they can access their Facebook. We found that has been really helpful in staying connected with people, especially as they become transient, and, really being able to follow up with them and keep them engaged, so that we can get them into treatment when they're ready.

Sade: What communication platforms are you using?

Tiffany: Social media is a big one. Obviously, just your traditional forms of communication as well. We've had. . .any way that we can get in touch with someone, any preference they have for communication. So if they would rather have an email or a message on Facebook, or less common for our population to be on WhatsApp, but I know that that's something that they have used with some. They've done like the Google Hangout with some people before, especially during this time, since the pandemic. But any preference that the individual has, our workers, our coordinators, our peer supporters will use it to keep in touch with them.

They all have work phones, so that it's not on their personal devices. And they all have, basically, like, work accounts so that it keeps that separation. We want to ensure that we keep some boundaries. Peer support is probably the hardest area for us to ensure that there's a maintenance of boundaries, and we've learned as we went, how to keep those professional. But also, it's a lot different having a peer

supporter, and the types of services they're providing is a lot different than your traditional kind of clinical services. The whole point is, is that they can share their lived experiences, that they can connect with them on a different level. And so that's been a balance. But yeah, anything that the individual wants in terms of communication, we try to, to meet them where they're at.

Sade: Can you talk a little bit more about what guidelines you have put in place for peer specialist technology use?

Tiffany: For their usage of technology, we basically want them to have some boundaries and we want to ensure that there is some protections for them and for the client. They have work-issued devices, cell phones, laptops, tablets, whatever it may be. Each individual is a little different in terms of their preferences, but they all have work devices. So the numbers they can give out to clients, is a work cell phone number, not their personal cell phone number. For social media, they've actually set up a profile that is not their personal profile. So basically, they've set up profiles that are, it'll have their first name. So for example, Lindsey is the lead of the care Coordinators team—she's been on Facebook the longest. So her profile is Lindsey Butler. Her last name's not Butler. We're in Butler County. That's where she got the Butler from, but what she posts on that page is typically only posts or shares recovery messaging, encouraging messaging, but the real tool for that is to be able to private message and get in touch with people and people to be able to private message her through Facebook Messenger. That's the key, is to keep their personal devices and their

personal accounts separate from their work ones. And we've seen that work really well, because they can turn off their work device. They can have a voicemail, or a message set up on their work device that, you know, refers clients and emergencies to other areas, so that they're not constantly on call. We learned that from early on. They do take calls pretty frequently, but they can turn their work devices off. They can forward those calls, when needed, to other specialists, other coordinators. So we've really tried to separate the personal from the professional in that way.

Sade: How are you preventing or addressing staff burnout?

Tiffany: We've actually been pretty lucky in terms of who, who we found, and, and the workers we have. So part of that is being very selective in the hiring process and being very open with them about what the job entails. Most of our, you know, if we have a position we're looking to fill, part of the interview requirement is a like ride-along or a tag-along for a few, for at least a few hours, so they can see what they're getting themselves into. And we've had a few choose to not continue, because once they actually saw what we were talking about, they were like, this isn't going to be for me. So that's been really telling, where up until that point, they were super gung ho. We take care in the beginning part of the process to make sure that people are aware of what they're signing up for and the type of work that they're signing up to do.

The other piece is, we really foster a team so that they can rely on each other. And I think that that has been really key in preventing the

burnout, is that one of them is having a hard time, they feel like they can communicate, and the others can pick things up. That's been a big piece. Separating the personal and professional has been big, too, because that was kind of a lesson learned, when we only had one care coordinator, is, Lindsay felt like she couldn't turn off her phone, even if she was on vacation. So we really have built in a process for forwarding calls, for setting messages up that says like, "I'm currently out of town, please contact so-and-so," and having those kinds of follow-ups and, and building. . .the supports within the team has been really, really successful.

The other big thing is highlighting their successes and showing them the impact that they're having, because all the people are part of that kind of hiring selection process. They all have a passion for the work and want to help people. And so it's, it's being able to foster that passion, while not allowing that passion to consume and, and lead to the burnout. So we've been really trying to provide some balance for all of them, and encouraging balance. And I think by them seeing others be able to successfully do it. . .where the more veteran ones are modeling the behavior for the newer ones, and I think that that's been really successful.

Sade:	How has the current climate or the global pandemic impacted your service provision?
Tiffany:	Quite a bit, initially. QRTs are very much a physical and hands-on program. So they stopped going out through the stay-at-home order. What we did have is, we've got really good relationships with our

police and fire departments that partner with us on the QRTs. So a few of them were still doing follow-up, still going out, just without the coordinators, and so we were able to make some connections that way. But what we did was, we shifted to much more virtual conversations instead of in-person conversations. We shifted to not providing transportation by the peer supporters and linking individuals with Lyft or a cab, or finding, you know, a family member or a friend that could transport instead, and really, really upped how we did that. That was probably the biggest change. There was about a period of a month when the sheriff's office would not allow the peer supporter into the jail—that was challenging, but we were doing a much better job in communicating, so that she was able to get in touch with people the day they were released. We shifted too; she's now back in the jail. Our peer supporter in the ER never left the ER. They continued to have her there and viewed her as an essential service. So they never asked her to leave, which was great, and she was comfortable being there. And I would say the biggest thing has been finding ways to get to people that aren't as easy to find, because people aren't going out as much. So we shifted to much more of a harm reduction model during the pandemic, even more so than we had before. So we pulled together, basically, a community harm-reduction team. I started getting weekly reports from our coroner's office and our health department regarding ER visits, so that we could keep an eye on what was happening in the community and get word out on things that we were seeing, you know, through social media, through

communications. So we did see two small spike of overdoses, so far, during the pandemic, but they were literally like for a week and then for one day. And I think that we were successful in being able to get word out when we noticed things happening in the community, because we kept those communication lines open and kind of created that community of communication amongst outreach workers.

Sade: Overall, the experience with the unexpected shifts to peer support, primarily through technology-assisted peer support, has been a positive one. Even after this pandemic, many programs anticipated seeing more virtual supports offered alongside in-person support. That completes this episode. Thank you for listening to this podcast. If the work being done by these programs is interesting to you, or you are interested in starting similar programs using peer recovery support, please consider reaching out to us for training and technical assistance opportunities. This podcast was brought to you by the Peer Recovery Support Services Training and Technical Assistance Center. The project [is] funded by the Bureau of Justice Assistance Comprehensive Opioid, Stimulant, and Substance Abuse Program and staffed by Altarum.

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