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Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP)

Peer Recovery Support Services in New York Opioid Intervention Courts:

Essential Elements and Processes for Effective Integration

Abstract

Opioid intervention courts (OICs)—a relatively new form of treatment and recovery court—have shown early promise in addressing the needs of justice-involved individuals with opioid use disorders (OUDs). This article describes the efforts of New York State OICs to heighten their impact by incorporating peer recovery support services (PRSS) into their work. The authors present a framework for conceptualizing the adaptation and integration of PRSS into court settings, identifying essential elements of comprehensive programs, essential integration processes, key program design factors, and drivers of success. The framework suggests that while the core elements remain the same, effective integration of PRSS programs will vary from site to site.

Introduction

The opioid epidemic continues to have devastating consequences across the United States with more than 70,000 Americans dying from a drug overdose in 2019, 71 percent of those overdoses involving opioids (*Overdose Death Rates National Institute on Drug Abuse [NIDA], 2021*). Heroin, prescription pain relievers, and synthetic opioids,

like fentanyl, have contributed to this epidemic. The New York State Department of Health 2019 Annual Report indicates that “deaths involving opioids tripled from 2010–2017, from 5.4–16.1 deaths/100,000 population” (New York State Department of Health, 2019). The Centers for Disease Control and Prevention’s (CDC) provisional data posits that “overdose death rates in NYS [New York State] increased 30% from October 2019 to October 2021, which is an historically high increase” (CDC, 2021). Effectively addressing the epidemic—including preventing opioid use morbidities and mortalities—requires a collaborative and comprehensive approach across multidisciplinary systems.

Increasingly, PRSS are being incorporated into programs in various settings as a part of diversified efforts to address opioid use disorders. The New York State Office of Court Administration (OCA) is working to integrate peer recovery professionals into its OICs as it adopts this new model for saving lives. As a part of those efforts, a conceptual framework was developed to assist the courts in successfully conceptualizing, planning, and integrating peers into their work. This article describes the innovation involved in integrating PRSS into OICs, their framework components, and early lessons learned.

The Emergence of a New Court Model: The Opioid Intervention Court

Since the late 1980s, treatment courts, problem-solving courts, or specialty courts have developed into a widely used approach to address the needs of justice-involved individuals with behavioral health needs. These courts disrupt the cycle of relapse, crime, and reincarceration by working to resolve the underlying personal issues related to justice involvement (Schaffer, 2011; Michell et al., 2012). The first—and arguably best known—of these courts were drug treatment courts launched in Miami-Dade County, Florida. Family courts, mental health courts, and veterans' courts followed. There are now more than 3,000 such courts in the United States, serving approximately 120,000 individuals annually (Office of National Drug Control Policy, 2011). This article refers to these courts by the emerging term “treatment and recovery courts” (TRCs) as it reflects their overarching purpose.

Opioid intervention courts (OICs) are the newest addition to the TRC contingent. OICs present opportunities to address the opioid epidemic and prevent overdose deaths by immediately linking participants to evidence-based treatment, including medication-assisted treatment (MAT) and recovery support services. OICs differ from drug courts in several ways: they are pre-plea, voluntary (in that they do not rely on legal leverage), short-term, and focused on stabilization and crisis intervention. Drug courts are analogous to a long-term care hospital, providing extended support for court-involved individuals with substance use disorders (SUDs); OICs are like emergency rooms, offering short-term services to individuals at high risk of overdose to prevent overdose and reduce other barriers while encouraging early steps toward recovery. The country's first OIC was launched in Buffalo, New York, in 2017. Since then, multiple jurisdictions have adopted the model, which relies on day-of-arrest intervention, OUD treatment, daily judicial supervision, and wraparound services. The Center for Court Innovation (2019) described the Buffalo OIC's operations as follows:

Prior to arraignment, court staff go to the jail to interview defendants, using a brief survey developed by the court to identify those at risk of opioid overdose. Individuals identified to be at high risk are administered a biopsychosocial screening by an on-site team of treatment professionals and case coordinators immediately following arraignment. Based on the results, each consenting individual is transported to an appropriate treatment provider, where most begin medication-assisted treatment with buprenorphine, methadone, or naltrexone. The process of initial interview, arraignment, biopsychosocial screening, and transfer to treatment is completed within 24 hours of arrest.

Once connected with a treatment provider, the participant receives a comprehensive clinical assessment and an individualized treatment plan. OIC staff provide daily case management for participants, including helping with transportation, doing curfew checks, and linking participants with a primary medical doctor and a range of recovery support services. Participants must return to the opioid court every business day for 90 days to see the judge for progress updates. Participants are randomly tested for drugs to monitor their clinical needs. The court does not sanction participants for positive drug tests; rather the results of the toxicology test are used to make adjustments to the participant's treatment plan, such as increasing treatment intensity or changing medications, and to help the court recognize when a participant is in danger While a defendant is participating in the Buffalo Opioid Court, the prosecutor's office suspends prosecution of the case.

The Buffalo OIC has shown promise. Findings from an evaluation of the Buffalo OIC, conducted by NPC Research, demonstrate that OIC participant death rates “were reduced by half and [participants] had lower rates of recidivism when compared to opioid users who were traditionally processed through the criminal justice system and indicate a cost savings of \$301,744/participant” (NPC, 2020). As a result,

the NYS OCA is developing OICs in every judicial district. The goal is to integrate this new collaborative care model across the state, prioritizing interventions for offenders at high risk of overdose.

In February 2019, the NYS OCA's Division of Policy and Planning, in cooperation with the Center for Court Innovation (The Center), released the first state guidelines that defined this new problem-solving court based on the Buffalo model. The Center then worked with court and treatment experts to draft national guidelines published in *The 10 Essential Elements of Opioid Intervention Courts* (Center for Court Innovation, 2019), with the support of the U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance (BJA); the Substance Abuse and Mental Health Services Administration (SAMHSA); and the Center for Substance Abuse Treatment (CSAT). The "Essential Elements" include a focus on broad legal eligibility, immediate screening for risk of overdose, informed consent after consultation with defense counsel, suspension of prosecution during stabilization, rapid clinical assessment, the immediacy of medication for opioid use disorder (MOUD), the use of evidence-based treatment for opioid and polysubstance abuse, frequent judicial supervision, intensive case management, and performance evaluation metrics to identify service gaps and make program improvements. **An essential core element of OICs is recovery support services, including PRSS**—non-clinical, social supports provided by persons with lived experience of addiction, recovery, and criminal justice involvement. **PRSS are critical to the operation of OICs due to the voluntary nature of the court model and the need for immediate engagement in services and supports to address the high risk of overdose.**

According to the Centers for Medicare & Medicaid Services (CMS), peer support services are an evidence-based model of care in which a qualified peer recovery professional assists an individual with their recovery from substance use and mental health disorders (CMS, 2007). Research findings to date tentatively speak to the potential of PRSS to improve outcomes across a variety of settings, including

reduced substance use and SUDs, decreased return to use rates, improved relationships with treatment providers and social supports, increased treatment retention, and greater treatment satisfaction (Eddie et al., 2019). Research suggests PRSS in community-based programs may lead to increased use of detoxification programs and residential SUD treatment (Deering et al., 2011), as well as reduced rehospitalization rates following treatment (Min et al., 2007). Research also suggests that integration of PRSS services can assist in getting individuals to treatment faster following SUD treatment referral (James, Rivera, and Shafer, 2014), as well as reducing criminal behavior and recidivism rates (Rowe et al., 2007; O'Connell et al., 2017). SUDs are chronic and require long-term management to maintain recovery. Peer recovery professionals provide a "range of person-centered and strength-based supports for long-term recovery management. These supports help people in recovery build recovery capital—the internal and external resources necessary to begin and maintain recovery" (Best and Laudet, 2010; Cloud and Granfield, 2008).

Through the engagement and employment of peer recovery professionals in TRC, programming has grown over the past several years partly at the behest of funders as these services are not yet well-researched. Two studies show their promise. The first study indicates that peer support groups may help address racial disparities in graduation rates (Gallager and Wahler, 2017). The second study found that recidivism rates for court graduates who were matched with peer recovery professionals were reduced by half (Belenko, LaPollo, Gesser, and Peters, 2018; Belenko, LaPollo, Marlowe, Rivera, and Schmonsees, 2019; Belenko et al., 2019).

Adding Peer Recovery Support Services to Treatment and Recovery Courts

In theory, adding PRSS to TRCs is a straightforward undertaking: Simply add peer recovery professionals to the existing multidisciplinary teams composed of judges, prosecutors, defense attorneys, court administrators,

behavioral health clinicians, social workers, and other court staff. In practice, it is more complex because of the nature of peer relationships, the variety of roles and tasks that peer professionals can have, and the range of possible peer supports.

The term **“peer”** identifies a single person with relevant lived experience, a designation that positions the person as distinct from others. PRSS programs are grounded in a set of principles that have emerged from the experience of people in long-term recovery and their allies. The primary principle is that “recovery is a strengths-based process,” which keeps the focus on building recovery capital and developing self-efficacy, while understanding that the process of change can look different based on the individual. Acknowledgment of the change process is another primary principle in meeting individuals “where they are at.” Peer recovery professionals are supportive, rather than directive or prescriptive, and focus on building strengths and resiliencies. Thus, recovery becomes a primary focus for both the peer professional and the individual seeking support. Other foundational principles relate to the authority and expertise of lived experience (Borkman, 1976; Riddick, 2017), mutuality, collaboration, and reciprocity, with relationships built on respect, trust, self-efficacy, and empowerment (White, 2009a; Reif et al., 2014; Hoffman et al., 2019).

In combining their lived experience of addiction, recovery, and criminal justice involvement with practice-specific training, peer profession-specific ethics, and role-specific certification, peer recovery professionals bring unique philosophies, values, skills, and resources to supporting individuals on their path to recovery—known as **“peer practice.”** Peer practice arose to address the limitations of the acute care model for treating addiction; it supports individuals along their path of recovery before, during, after, or instead of treatment (White, 2009a). This approach may conflict with that of other specialties on the TRC multidisciplinary team, especially medically focused ones.

Peer recovery professionals have many different titles and roles, depending on the setting and context. Additionally, similar roles may have different titles based on jurisdiction and regulatory oversight bodies. In the SUD realm, in New York State, the most well-known title is the certified recovery peer advocate (CRPA). Others, including forensic peer recovery specialists, peer navigators, or crisis interventionists, are summarized in table 1. The core body of knowledge is the same across the roles, but the focus of the core competencies varies in different contexts.

Table 1. Examples of Peer Recovery Specialist Roles

Title/Role	Key Tasks	Locations
Certified Recovery Peer Advocate/ Recovery Coach Family-Supported Recovery	Guide and mentor the person seeking or in recovery, help identify and remove obstacles and barriers, and support connections to the recovery community and other resources useful for building recovery capital.	Recovery community centers, correctional settings, inpatient and outpatient SUD treatment programs, behavioral health clinics, community-based settings, recovery residences
Forensic Peer Specialist	Support people involved with the criminal justice system as a mentor, guide, and resource connector while the individual is incarcerated, on probation or in lieu of probation, or in the reentry process.	Jails, prisons, jail diversion programs, drug courts, community-based programs
Recovery/Crisis Interventionist	Provide support and guidance to the person at an early (crisis) intercept point along the recovery support continuum, linking them to treatment or other recovery support services as requested.	Hospital emergency rooms, police and fire departments, community-based street outreach or harm reduction programs, crisis centers

Title/Role	Key Tasks	Locations
Peer Navigator	Provide support and guidance for accessing appropriate services from complex medical, treatment, and social service systems, including the application process for health insurance and other entitlement benefits.	Community-based street outreach or harm reduction programs, community health clinics, public health departments

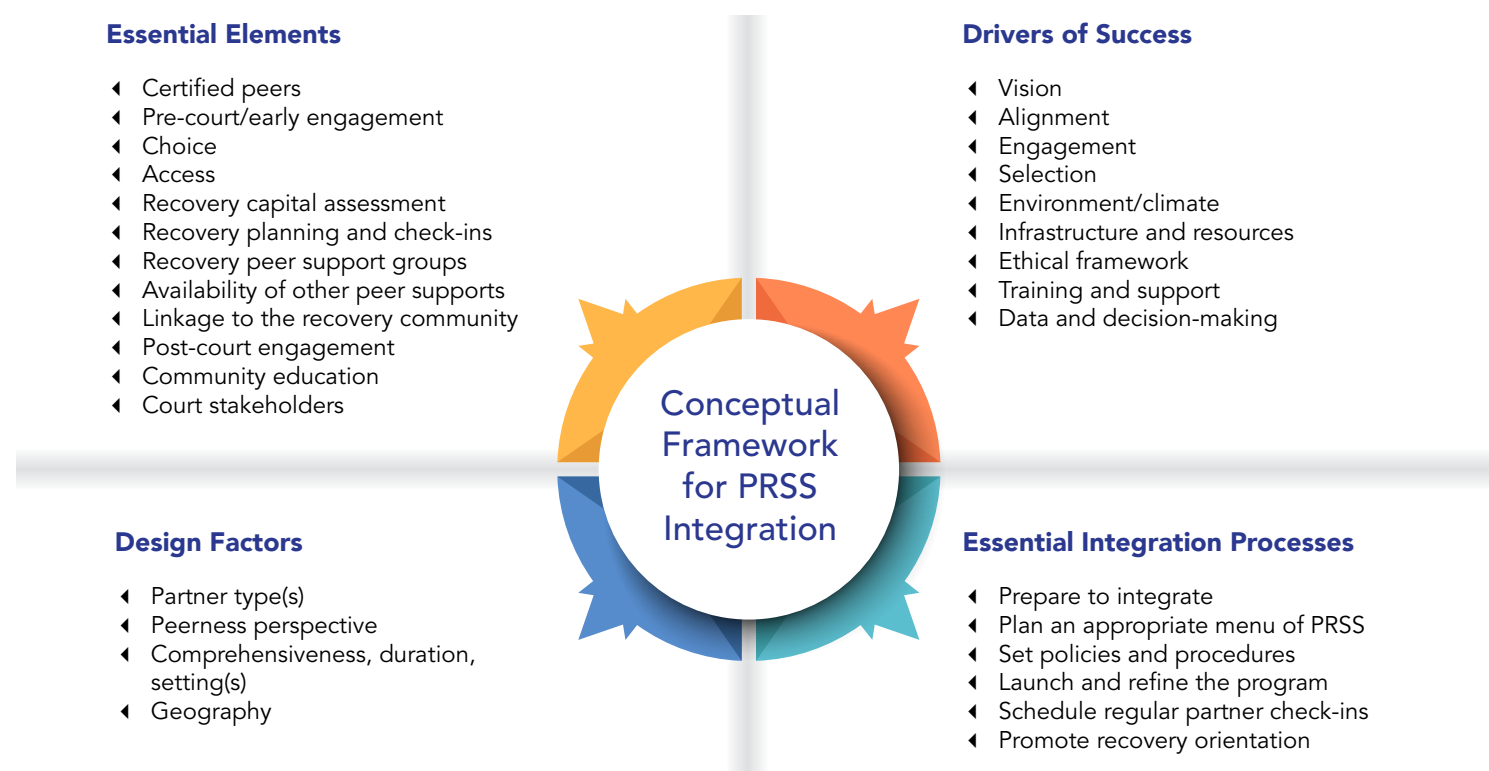
PRSS are person-centered: Through recovery (goal) planning and resource sharing, a peer recovery professional assists others in building their recovery capital—a process of making healthful choices, creating or recreating a meaningful life, and being of service to family, friends, and community, leading to a sustainable life in recovery. There are four categories of social support: (1) emotional, (2) instrumental, (3) informational, and (4) affiliational (Cobb, 1976; Salzer, 2002). Under this schema, a wide array of PRSS can be offered. Examples for each category are provided in table 2.

The multifaceted nature of PRSS provides them with an ability to adapt to a variety of settings. However, successful integration takes careful forethought. NYS OCA approached the Training and Technical Assistance Center for PRSS, funded by BJA, to assist new and emerging OICs. The New York State Unified Court System (NYS UCS) worked with Altarum to develop a conceptual framework, summarized in figure 1, that courts can use to conceptualize, plan, and integrate PRSS successfully.

Table 2. Types of Peer Recovery Support Services

Type of Support	Description	PRSS Examples	Tech-assisted PRSS Examples
Emotional	Demonstrate empathy, care, or concern to bolster self-esteem, confidence, and hope.	- One-on-one peer mentoring or coaching - Peer-led support groups - Provision of support during challenging moments - Modeling the use of recovery-oriented skill sets	- Telephone recovery support - Video recovery check-ins - Zoom support groups
Informational	Share knowledge and information, and provide life or vocational skills training.	- Discussing the therapeutic court process - Training for job readiness - Offering wellness seminars or classes - Training on self-advocacy - Offering parenting classes	- One-time webinars - Learning communities - Self-directed learning modules
Instrumental	Provide concrete assistance to help accomplish tasks, increase access and opportunities, and reduce barriers.	- Accessing community health and social services - Providing housing or child-care vouchers - Providing public transportation passes	- Tech on loan - Paperwork clinic - Online resource bulletin board
Affiliational	Facilitate contacts with other people to promote learning of social and recreational skills, create community, and foster a sense of belonging.	- Arranging outings or activities, such as sober sports, alcohol and drug-free dances, movie nights - Celebrations and rituals	- Community coffee breaks - Live-streamed group activities (e.g., meditation, yoga, fitness) - Game playing sessions

Figure 1. Conceptual Framework for PRSS Integration



Essential Elements of PRSS in Treatment and Recovery Courts

Following the example of *The Ten Essential Elements of Opioid Courts* (Center for Court Innovation, 2019), NYS OCA sought to define the essential elements of peer support services in OICs. Three primary methods were used to identify potential elements: (1) review of relevant academic research; (2) examination of publications by court professional organizations; and (3) an audit of practices of court-affiliated PRSS programs across the country. What emerged were essential elements of peer support services in TRCs in general that can be applied to or adapted for OICs. These elements are described below.

Certified Peer Professionals

With the increasing interest in and expansion of peer support services, peer credentialing emerged in the early 2000s with state-recognized certification programs for mental health and SUD peer recovery professionals.

Certification standardizes the core body of knowledge and core competencies for the role at entry and advanced levels. Candidates demonstrate their proficiency in meeting the competency and ethical requirements set by independent certification boards through an examination and/or other competency assessment. In many states, certifications also help provide access to a reliable funding stream, as services provided by certified peers become Medicaid-billable. In the TRC context, it is essential to select and hire certified peers or partner with an agency that hires them, such as an SUD treatment provider, social service agency, or recovery community organization.

In New York, **“certified peer specialist”** is a term that is reserved for mental health peers; SUD peers whose services are Medicaid-reimbursable are called CRPAs. CRPAs have practice-specific education, profession-specific ethics, and role-specific certification. They “bridge the gap between clinical prevention-treatment providers and relevant multidimensional resources in the community” through “purposeful conversations using role modeling, motivating,

problem solving, and resourcing” (adapted from training materials by Ruth Riddick, Sobriety Together, 2017). In NYS OICs, CRPAs are integral parts of the multidisciplinary opioid court team, providing support to participants during a very challenging time; their roles and tasks employed within the NYS OIC system are summarized in the boxes in figure 2.

Pre-Court/Early Engagement With Peer Recovery Professionals

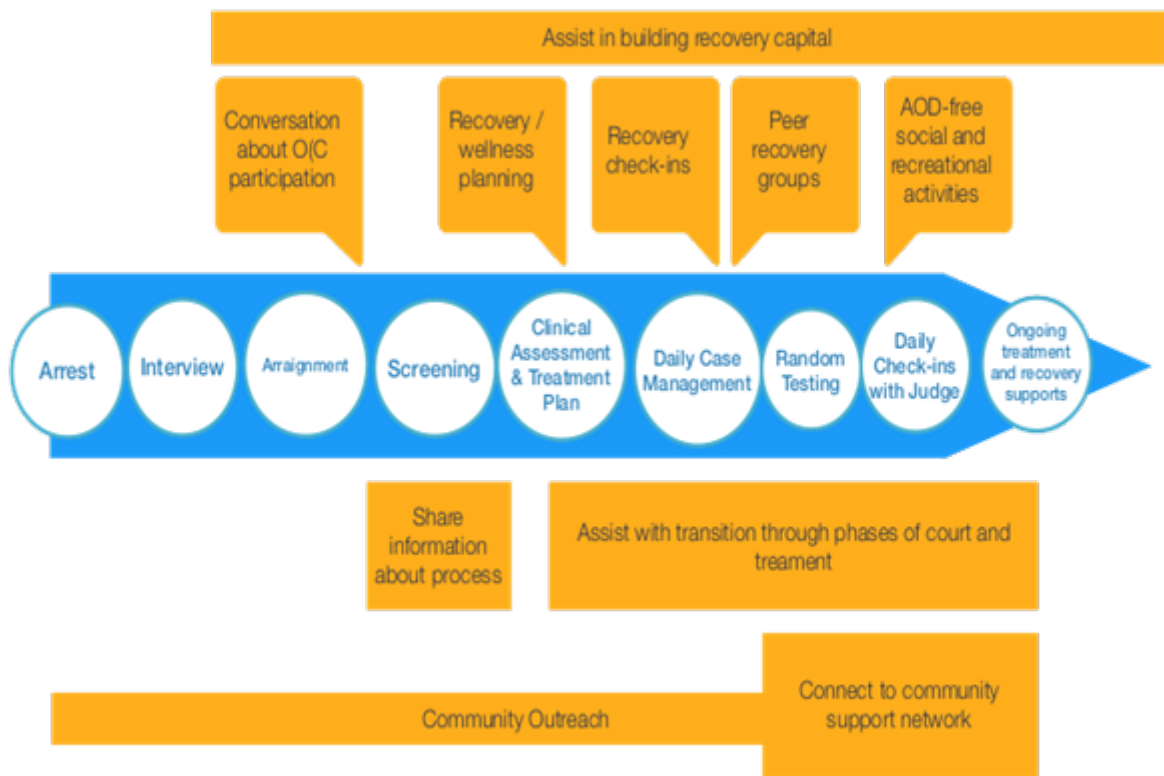
Peer recovery professionals have the ability to engage individuals outside the formal structures of the court and traditional clinical service locations. This provides an opportunity to fill critical gaps to keep individuals from disconnecting or withdrawing from treatment and/or services. Research suggests outreach by peer recovery professionals may increase individuals’ self-awareness of problematic substance use (Boyd et al., 2005) and lead to greater utilization of services among those needing treatment (Deering et al., 2011).

NYS OICs incorporate CRPAs into the court process as early as possible to engage individuals in a supportive and productive way. In several NYS courts, the CRPA is the first person point of contact for individuals who are considering participation in the OIC. Court administrators stated that having the first engagement be with a peer rather than a court staff member changes the dynamic. Individuals appear to be more receptive to the information received from a peer because of their lived experience, meaning they can relate to the situational experiences the individuals present with. Individuals perceive the CRPA as helping them through shared experience to make an autonomous decision to participate in the court programming.

Choice

Choice, self-direction, and empowerment are foundational values of PRSS. These are put into practice in several ways, such as supporting the many pathways to recovery, believing the person seeking recovery is fully capable of making informed choices, and respecting an individual’s

Figure 2. Opioid Intervention Court Activities and CRPA Tasks



goals, objectives, and preferences (SAMHSA CSAT, 2009). In the general court context, choice means that an individual should be able to choose whether to participate in peer supports. Since participation in OICs is voluntary, the choice is whether to engage with the court at all. This re-emphasizes the early role of the peer recovery professional and points to the need for harm reduction and recovery supports if the individual elects not to participate in OIC.

Access

Peer support services and peer recovery professionals need to be easily accessible to court participants in terms of location and time of day so that supports are available as they are needed. There are several strategies for facilitating access: having peer recovery professionals at the court during its hours of operation, offering mobile services, providing access to peers in community-based settings, or offering technology-assisted (phone, text, web-based) peer support services. One respondent noted that a CRPA is available to their OIC participants 24 hours a day for crisis support and to offer recovery supports between traditional service appointments. Another noted that CRPAs could be effective in preventing relapse. When a participant shares that they are thinking of returning to using, the CRPA can offer strategies for intervening on such thoughts and feelings as well as options, such as taking the person to a treatment center if asked. The ability to connect with individuals is also important for peer recovery professionals to effectively do their work. According to respondents, CRPAs gauge the level of contact needed. The barriers they may have in connecting with participants—initially and on an ongoing basis—need to be assessed and addressed within the program design.

Recovery Capital Assessment

Recovery is a journey that involves building recovery capital, which is the sum of the strengths and supports—both internal and external—that are available to help someone initiate and sustain long-term recovery from addiction (Granfield and Cloud, 2004; White, 2008). Stable recovery

is best predicted on the basis of recovery assets, not pathologies (White and Cloud, 2008). A recovery capital assessment is a strengths-based tool to measure the strengths, resources, motivation, and aspirations that court participants have that can support them in their recovery journey (Groshkova, Best, and White, 2013). It is also a tool that programs can use to quantify individual-level (Laudet and White, 2008; Sánchez, Sahker, and Arndt, 2020) and program-level recovery outcomes (as opposed to treatment outcomes).

TRCs can also play an important role in expanding community recovery capital by partnering to create physical, psychological, and social spaces in the community within which recovery can thrive (White, 2008; White, 2009; Evans, Lamb, and White, 2013; Altarum Institute, 2017). In doing so, programs can also use the aggregate results of recovery capital assessments to assess changes in community recovery capital.

Recovery Planning and Recovery Check-Ins

A recovery capital assessment is a strengths-based tool to chart current progress and help to identify opportunities for growth. The recovery plan is a roadmap that takes into account the specific strengths, desires, and motivations of the recovering individual. Recovery planning assists individuals in (a) articulating and visualizing the kind of life they would like to have in recovery, (b) outlining their personal recovery goals, (c) developing action steps to achieve their goals related to the essentials for sustained recovery (e.g., a safe and affordable place to live, steady employment and job readiness, educational and vocational skills, life and recovery skills, health and wellness, a sense of belonging and purpose, community and civic engagement, and recovery support networks), and (d) can act as an evaluation tool for individuals to assess where they are in their recovery process and make revisions to their action steps and goals as needed.

Recovery check-ins improve the likelihood of sustained sobriety and engagement in a recovery program (Scott and Dennis, 2003). They provide opportunities for participants

to reflect on progress toward the goals they set in their recovery plan, talk about challenges and barriers, and identify resources (Braucht, n.d.). The check-in can also serve as a reminder of the next scheduled court, treatment, or social services appointment. Additionally, check-ins also help to develop individual accountability and begin the process of encouraging self-efficacy.

The practice of recovery planning and check-ins will vary depending on both individual and program factors. For one NYS OIC, there are three built-in meetings (mandatory check-ins): (1) an overdose awareness workshop (first month), (2) a medication management workshop, and (3) a discharge planning workshop. The program also encourages participants to have check-ins with their peer recovery professional each time that they appear in court. Another operates off a different schedule: in the initial stages of the engagement, the peer recovery professional helps participants in the development of their wellness plan. They schedule check-ins based on the goals participants identify they want to achieve. The wellness plan will help to determine the number and frequency of check-ins that might be helpful. Recovery check-ins should be scheduled at regular intervals, more frequently in early recovery and at transition points, less frequently as time progresses, and as participants become more established in their recovery.

Recovery Peer Support Groups

In addition to one-on-one support, peer-facilitated or peer-led groups are another type of resource that may help individuals with establishing and maintaining their recovery. Research has shown that such groups, in combination with other peer services, can increase sobriety, reduce the return to use, and increase satisfaction with treatment (Tracy and Wallace, 2016). Groups can be structured or semi-structured in their format, provide educational or emotional support, or have mixed components. They can be formed around a shared identity, such as belonging to a common cultural group or gender or a shared experience related to building a sustainable life in recovery. Group educational activities often focus on a specific subject or skill and may

involve the participation of a subject-matter expert. Peer support groups also offer unique advantages for engaging underserved or difficult-to-engage populations (Rowe et al., 2007; Tracy et al., 2011) as they may build rapport based on shared experiences.

Availability of Other Peer Supports

Collaborating with a peer recovery professional on recovery capital assessments, recovery planning, and recovery check-ins strengthens the desire, motivation, and coping skills for change, all of which may be helpful in establishing and maintaining recovery. Opportunities to practice new skills in safe and supportive environments (offered through options such as classes, workshops, and social and recreational activities) have also been found to be helpful (O’Connell et al., 2017; Page and Townsend, 2018; Best et al., 2020). These extended informational and affiliational supports may be difficult to offer within the TRC setting; therefore, partnering with the community provides opportunities to increase access to those resources that can support meaningful and lasting change.

Linkage to Broader Recovery Community

It is said that the opposite of addiction is not sobriety but connection (Johann Hari). Leamy et al. (2011) posited that the essential elements of recovery are connectedness, hope, a positive sense of identity, meaning, and empowerment. Research indicates there are two social factors—social learning and social control—that impact long-term recovery. Making the transition from peer groups focused on drug use to those that are recovery-focused is also key (Best, Irving, and Albertson, 2017). Linking participants to a broader recovery community may assist individuals in building a sustainable life in recovery for three key reasons: (1) community engagement can offer a positive sense of identity, belonging, and purpose; (2) community engagement builds pro-social, recovery-oriented networks; and (3) community engagement increases opportunities to access community recovery capital (White, 2009b; Best et al., 2012; Kelley et al., 2017; Best, Musgrove, and Hall, 2018).

Post-Court Engagement

TRCs facilitate treatment initiation and support participants in their early steps to recovery, often for a year or more. However, research tells us that, on average, a person's recovery progresses in stages across several years (Dennis, Foss, and Scott, 2007; CCAR training materials). Peer support services can assist individuals throughout their entire recovery journey. In the OIC setting, post-court engagement is helpful for extending the reach of short-term programs. In NYS, some OICs allow for the voluntary continuation of the program after 90 days or a referral to post-plea drug-treatment courts. Post-court engagement allows for participants to continue their check-ins with a peer recovery professional—albeit perhaps less frequently—and receive encouragement, mentoring, and assistance with accessing resources as needed.

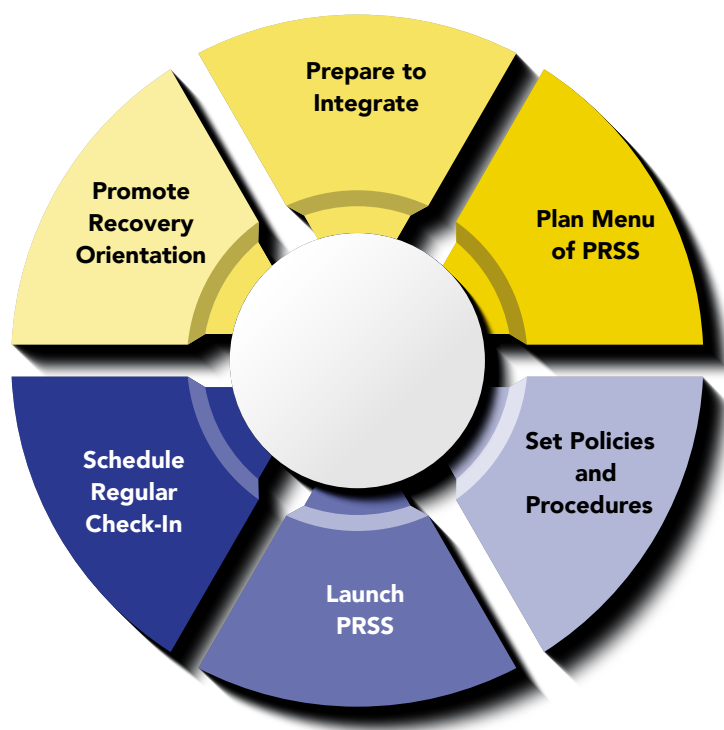
The essential elements described above define a comprehensive model for peer support services in TRCs. Not all programs will offer all the elements at their initiation, nor do TRCs need to provide these alone. As with other programming, the role of court staff members is to ensure that the elements are met through effective, strategic partnerships. Lastly, the elements are flexible in that there is room for each court to adapt them to reflect local conditions, resources, and constraints.

Essential Processes for Integrating PRSS

The essential elements of PRSS offer guidance as to what comprises an effective PRSS program. The accompanying essential processes describe how to develop such a program. The core processes are shown in figure 3.

The development of these processes was informed by research related to organizational development, diffusion of innovations (Rogers, 2005), and implementation science (Motes, 2007; Deering, 2009; Earhart, Aarons and Farahnak, 2014; Weiner, 2020). The experience of the development team with the integration of PRSS in other settings and the practices of the emerging NYS OICs also inform this model.

Figure 3. Processes for Effective Integration



Preparing to Integrate Peers Into Court Processes

Preparing to integrate peer recovery professionals and peer support services increases staff and organizational readiness for the launch of PRSS. This process provides a foundation for exploring staffing, workflow, decision-making, communications, and other practices, along with building a commitment to making the changes necessary for peer work to be effective. It encourages a focus on the following questions: What is the value to us in making this change? Do we know what it will take to implement this change effectively? Do we have the resources to implement it? Can we implement this change given the current situation? Key preparation tasks include conducting an organizational self-assessment; identifying the specific roles, activities, and expectations that the program has for peer staff members; clarifying whether and how peer recovery professionals will be integrated into collaborative court case staffing; and negotiating roles and expectations of partners.

Planning Appropriate Agency Services

The overarching purpose of peer support services is to help individuals build a sustainable life in recovery. SAMHSA defines recovery as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential (SAMHSA, 2011). An appropriate description of peer support services helps individuals with each of these dimensions. Some services may be provided directly by the TRC; others may be offered by, or in collaboration with, community partners. The key is to ensure that a full range of services is available to program participants across many pathways to recovery, with the intensity and length of time necessary for the individual to establish a stable path to recovery.

Services will ideally include one-on-one collaboration (e.g., recovery capital assessment, recovery planning, recovery coaching), group engagements (e.g., classes from which all participants may derive value, groups that seek to further the recovery process, group social activities), as well as a consideration of the location where these services will be offered.

Set Policies and Procedures

As with any other facet of operations, organizational policies impact the nature and quality of PRSS. Some impacts may be influenced by restrictive policies or those written without peer practice in mind. Other impacts come from the absence of policies (e.g., transportation, workload, self-care). Policies reflect organizational culture, which, in turn, shapes the structure and functioning of a peer support program. While peer support services will be tailored to the characteristics of a specific court and its culture, it is also necessary to create new policies and procedures—and to review and adapt existing ones—to guide the work of all staff members.

Workflows will also need to be revised. Procedures should describe key tasks and associated tools (e.g., recovery plan, recovery capital assessment), offer approaches to addressing

common situations that a peer recovery professional may encounter, including the upholding of appropriate peer ethics and boundaries, and provide guidelines on when to ask for help from a supervisor or relevant team members. Additionally, a workflow should address the responsibilities and procedures around peer-related documentation and expectations for what information should be gathered and documented during peer-provided services. (These practices and limitations will be communicated by the peer to participating individuals at the start of any engagement.) Procedures also need to be in place to monitor and capture information about how well the program is working.

Policies and procedures will conform to agency and human resources standards governing all employees and will be sufficiently detailed in providing a clear framework for all staff members, partners, and participants to reference. As the process develops, changes may need to be made to adapt policies and procedures for individual TRCs. Evaluation of policies and procedures should occur as needed and as additional best practices are established.

Schedule Regular Check-Ins With Partners

After preparing, planning, and policy-setting, new PRSS programs should be poised to launch. It is important to build in a process for partners and stakeholders to meet to review how things are going. This may need to be more frequent at the beginning of a program but should continue throughout its life as changes and adaptations often need to be made due to changing community conditions. One respondent noted:

When the meetings are set up in advance, it doesn't become 'Uh-oh, we have to have this meeting.' It becomes a routine. Get as many stakeholders as possible available that can come and just sit down and say, 'Okay, how's it working, what do we need to tweak, what are some of the issues?' [For example,] communication issues, safety issues, best practices.

The early NYS OICs used both informal and formal partner check-ins, which helped to (a) inform appropriate resource

allocation, (b) identify potential problems and prevent them from escalating, and (c), as necessary, make moderate adjustments or adaptations to workflows and roles of peer recovery professionals and other relevant staff members. It is an ongoing process of change and adaptation.

These check-ins also serve as a forum to assess early progress and to answer important questions about program operations, including: Are the peer recovery professionals reaching the intended participants? If not, why not? How are other personnel, materials, space, time, and organizational/partner supports contributing to the program? Are the program components being delivered as intended? What have been the challenges or barriers for participants? What solutions are being developed/implemented to address these issues and improve both performance and program?

Promote Recovery Orientation Among Stakeholders

Recovery is not only an individual, personal transformation process; it happens within recovery-oriented systems of care (ROSC) and communities that are recovery-rich. This means that it is important to prepare community partners and stakeholders to perform the institution- and community-focused work that will set a context in which personal recovery can happen. The better the understanding of recovery—and the role that PRSS can play in that process—the better the chances for the successful launch and continuation of PRSS in your community. Successful strategies include: hosting meetings that mix treatment providers, allied professionals, individuals, and family members in recovery and grassroots community organizations; conducting ongoing focus groups, town meetings, and other listening forums; hosting recovery celebration events and recovery conferences; visibly promoting community recovery successes; mapping recovery capital by zip code; conducting recovery prevalence surveys; and establishing recovery-focused performance benchmarks (Evans, Lamb, and White, 2013).

Adapting Peer Supports for NYS Opioid Courts:

Early Observations About Design Factors, Drivers of Success, and Situational Factors

The NYS OICs across all 13 judicial districts are relatively new. As noted above, the first began in 2017, with 4 OICs in 2018 and now 25 in 2021 with several more in planning. We have identified design factors, drivers of success, and unique situational factors that affect their initiation.

Design Factors

The roles and task variations of peer recovery professionals are related to different aspects of program design. The first aspect is the type of partner that is responsible for the hiring of the professional and the delivery of the PRSS. Most are working with SUD treatment providers that are licensed by the New York Office of Addiction Services and Supports (OASAS); some of these providers are conventional outpatient programs, others specialize in MAT. A few of the OICs are partnering with social service agencies that have a harm reduction approach to the provision of peer support services. Other options for peer support service partners that are not yet in practice include public health departments that employ community health workers (public-health-focused peer practitioners) or a peer-led recovery community organization.

The second aspect could be called peerhood perspective. This is related to partnership but also relates to the court's view of the role of the peer recovery professional, the individuals they serve, and the purpose of these engagements. A peer practitioner is often viewed unhelpfully as an adjunct who is hired to support and reduce the work of other staff, an entry-level supplement to the behavioral health workforce whose job it is to complete routine tasks, or, more appropriately, as an autonomous new role focused on participant engagement and progress. These perspectives are neither discrete nor fixed. As program operations become more established, as the peer role becomes clearer, as peer supporter contributions

become more apparent, and as staff and partners assess the program, perspectives may shift. One respondent noted:

Staff were tentative about bringing peers on board. Once they saw them at work, they recognized the value almost immediately. Seeing how the peers interact with participants and the success they have had in engaging them and keeping them going—that changes people’s views. You gain more buy-in from staff.

A change in perspective can be particularly impactful among defense attorneys: As they learn that peer practitioners work in a constitutionally protected environment, defense counsel often allow greater access to their clients.

Other program design aspects leading to variations include the duration of court supervision, the settings in which peer support services are offered, and community size and location.

Table 3. Drivers of Successful Peer Programs

Vision	Defining how peer support services will benefit court participants; the general role of peer recovery professionals
Alignment	Ensuring compatible court philosophy, partner philosophies, and core philosophies of peer practice
Engagement	Fostering deep participation of persons with lived experience in planning and refining program design
Selection	Recruiting, hiring, and onboarding individuals who can use lived experience as a tool for inspiring hope, engendering empathy and compassion, finding the right persons for the positions
Environment/ Climate	Organizational context, setting, and culture can have a profound effect on the nature and quality of peer support services; create safe environments in which positive, trusting, peer-to-peer relationships can thrive More successful when peer practitioners and individuals (clients) meet other places than court—the stigma of criminal justice involvement and addiction
Infrastructure and Resources	Ensuring infrastructure and resources necessary for effective peer practice (including mentoring and supervision)
Ethical Framework for Service Delivery	Comprises the certification domain related to ethics (International Certification & Reciprocity Consortium [IC&RC]), the Alcoholism and Substance Abuse Providers of New York State (ASAP)-New York Certification Board Code of Ethical Conduct, the organization-specific ethics guidelines, and the program-specific code of ethics Regular supervision and check-ins on ethics and boundary issues that arise (e.g., one-on-one problem-solving during supervision and group problem-solving with other peer recovery professionals); appropriate boundaries (peer-to-peer, and peer recovery professionals to court)
Training and Support (Including Supervision)	Building and enhancing competencies of peer recovery professionals, program supervisors, court and partner staff, including an introduction to the criminal justice system; 10 key components of drug courts and best-practice standards; court observation to get familiar with the criminal justice system
Data and Decision- Making	Collecting and using data to support and inform decision-making; measurements that are recovery- and recovery-capital oriented rather than solely focused on abstinence or recidivism in criminal behavior

Drivers of Success

In addition, there are several other potential drivers of success that were ascertained from interviews with NYS OCA court administrators, summarized in table 3.

Situational Factors

Accessing and Enhancing Resources. To ensure that courts have the necessary resources, as well as to improve resources, the NYS UCS has developed strategic partnerships with the NYS Office of Addiction Services and Supports (OASAS) and the Alcoholism and Substance Abuse Providers of New York State (the State Peer Certification Board). These partners are actively engaged in the OIC initiative, supporting early training and technical assistance (TA) for court administrators. OASAS has also provided direct funding to its treatment providers for hiring CRPAs, dedicating a portion of SAMHSA State Opioid Response funds to the effort.

Fostering Organizational Readiness: The Unifying Role of NYS UCS. The NYS UCS has committed to developing the infrastructure needed for the integration of PRSS into each of the judicial districts. They have taken an active role in ensuring effective integration occurs, offering court system training and access to TA resources. NYS UCS has demonstrated an enduring commitment to improving justice systems to better serve the communities across the state. The UCS has a history and experience working with OASAS in developing, maintaining, and improving new services, which research indicates is needed to support sustained changes in practices (Van Dyke and Naoom, 2016).

Positive Experiences With Peers. Several of the NYS UCS judicial districts have existing peer programs in their other treatment courts. As they launch their OIC, they are determining how to adapt the existing PRSS to fit the new intervention. This approach will increase the likelihood of successful integration. One respondent noted:

We started integrating peers on a [previous] grant, and the population we are working with had some

significant challenges getting through the court process. When we brought the peers on, we found it to be really supportive and impactful. They offered a huge benefit to the participants, not only at the time of first engagement but also throughout that process. We learned that they provide support that we had to add into every project.

External Factors. Two significant external factors have slowed program implementation. In 2020, newly enacted reforms to the NYS bail system (Criminal Justice Reform Act or CJRA) went into effect; consequently, individuals arrested for low-level offenses are now issued a “desk ticket” to appear in court at a future date. “The new law also requires judges to only impose pretrial conditions of release that are the least restrictive conditions that will reasonably ensure a person appears for their court dates” (Rahman, 2019). CJRA amendments in April 2020 increased options for ordering release conditions that included mandated treatment and counseling. Even so, this amendment did not change the requirement that the court must make a finding based on flight risk to avoid prosecution prior to being able to impose such conditions as treatment or counseling (Rempel and Rodriguez, 2020). This effectively eliminates the initial contact point for OICs—post-arrest detainments at which immediate screening for overdose risk and conversations about the program occur. OICs have seen significantly decreased participation—and, more significantly, are reporting that individuals are returning to the community and overdosing before they can be reached. The COVID-19 pandemic has exacerbated the problem; OICs stopped all in-person appearances, and it is unclear how social distancing will impact future operations. As with many other services impacted by COVID-19, OICs are working diligently to explore the use of virtual platforms to connect participants with providers across all domains, including clinicians, MAT prescribers, and peers. It is important to note that additional legislative action may change the current CJRA process.

Both of these external factors should lead OICs to consider how to enhance early contact and engagement strategies—

approaches for which peer supporters are uniquely suited—and how PRSS might be expanded with existing community resources. This requires further community-based problem solving and collaborative efforts.

Conclusion

The ongoing opioid epidemic challenges health, human services, and criminal justice systems to develop innovative and comprehensive approaches to save lives. OICs are one innovation that holds great promise, connecting individuals at a high risk of overdose to evidence-based treatment and intensive judicial supervision. With the addition of peer support services, there is the potential for greater impact.

The experiences of early NYS OICs offered insights into what may be required to successfully adapt and integrate PRSS into court settings. In the conceptual framework presented in this article, we posit four dimensions derived from their experiences and from an examination of the broader field: (1) essential elements of comprehensive programs—core components that are grounded in current research and practice about PRSS; (2) design factors—significant conditions that impact program design; (3) essential integration processes—noteworthy activities that are linked to commitment, capacity, and efficacy for change; and (4) drivers of success—aspects of program structure and environment that affect PRSS integration.

The framework suggests that while the core elements remain the same, effective integration of PRSS programs will vary from site to site. Community collaboration, utilization of resources, adaptability, and innovative problem solving will continue to be drivers of success for NYS OIC programs.

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