# Strengthening Peer Support in Florida's Substance Use System of Care

## Florida Center for Behavioral Health Workforce

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# TABLE OF CONTENTS

**EVALUATION TEAM** ..... **2**

**ACKNOWLEDGEMENTS** ..... **3**

**TABLE OF CONTENTS** ..... **4**

**EXECUTIVE SUMMARY** ..... **6**

**INTRODUCTION** ..... **9**

*Overview* ..... *9*
*Background* ..... *10*
Substance Use Disorders: Prevalence and Impact ..... 10
Florida's Response ..... 11
Effectiveness and Use of Recovery Peer Specialists ..... 12
*Current Study* ..... *13*

**METHODS** ..... **14**

*Process and Policy Review* ..... *14*
Background Screening and Exemption ..... 14
Funding Models ..... 15
*Secondary Data Analysis* ..... *16*
Data Collection ..... 16
Outcome Variables ..... 17
Other Key Variables ..... 17
Data Analysis ..... 18
*Sample Characteristics* ..... *19*
DCF Disqualification from Exemption Data ..... 20
Managing Entity Expenditure Data ..... 20
*Mixed-Method Survey* ..... *21*
Sampling Procedures ..... 21
Survey Development ..... 23
Measures ..... 26
Data Analysis ..... 34
Sample Characteristics ..... 36
*Qualitative Interviews* ..... *39*
Data Analysis ..... 40
Sample Characteristics ..... 42

**RESULTS** ..... **43**

*Objective 1. Effectiveness of Peer Specialists* ..... *43*
Secondary Data Analysis ..... 43
Mixed-Method Survey ..... 46
*Objective 2: Barriers to Integrating and Retaining Peer Specialists* ..... *50*
*Objective 2a. An Exploration of Specific Barriers* ..... *50*
Mixed Method Survey ..... 50
Qualitative Interviews ..... 55
*Objective 2b. An Examination of Reasons for Exemption from Disqualification* ..... *59*
Process and Policy Review ..... 59
Secondary Data Analysis ..... 62
Mixed Method Survey ..... 63
Qualitative Interviews ..... 63
*Objective 3: Program and Funding Models* ..... *64*
Program Models ..... 65
Funding Models ..... 69

Qualitative Interviews ..... 76
*Objective 1: Examine the Effectiveness of Recovery Peer Specialists Supporting Floridians Affected by Substance Use Integrated Summary* ..... *77*
*Objective 2: Identify individual/workforce-related, institutional, legal, and procedural barriers to integrating and retaining peer specialists in Florida ROSCs Integrated Summary* ..... *78*
*Objective 3: Examine peer models across ROSCs and associated funding models within Florida and across U.S. states Integrated Summary* ..... *79*
*Limitations and Strengths* ..... *81*
Secondary Data ..... 81
Mixed Method Survey ..... 82
Qualitative Interviews ..... 84
*Next Steps* ..... *85*

**RECOMMENDATIONS ..... 86**

*Objective 4: Data-driven Recommendations to Advance Integration and Promote Sustainability* ..... *86*
4a. Effective Peer Models ..... 86
4b. Strategies to Improve Peer Integration across Coordinated Systems and Across Florida ..... 88
4c. Strategies to Improve the Peer Workforce Pipeline ..... 92
4d. Sustainable Funding Models ..... 98

**APPENDIX 1 – LITERATURE REVIEW ..... 100**

**APPENDIX 2 – DESCRIPTIVES AND STATISTICAL OUTPUTS ..... 104**

**APPENDIX 3 – REFERENCES ..... 129**

# EXECUTIVE SUMMARY

Florida has made significant investments in strengthening its behavioral health system, including expanding the role of Certified Recovery Peer Specialists (CRPSs) as part of the statewide approach to address substance use and promote long-term recovery. To further advance recovery-oriented practices and ensure accountability for these investments, the Department of Children and Families (DCF) has partnered with the Florida Center for Behavioral Health Workforce (FCBHW) to conduct a commissioned evaluation examining the effectiveness, integration, and sustainability of CRPSs across DCF-funded substance use treatment and recovery providers.

The evaluation employed a comprehensive mixed-methods design drawing on multiple complementary data sources. These included analysis of statewide administrative data on service utilization; a mixed-methods survey of Certified Recovery Peer Specialists and supervisors across Florida; in-depth qualitative interviews with peers, supervisors, and administrators; and a structured review of relevant statutes, policies, and certification requirements governing peer services. Together, these data sources provided a nuanced understanding of Florida's peer workforce, including how CRPSs are deployed within DCF-funded services, their perceived and measurable effectiveness, and the organizational and procedural factors influencing their integration, role clarity, and sustainability. The evaluation was grounded in four primary objectives:

1. Examine the effectiveness of CRPSs across treatment and recovery settings.
2. Identify workforce, organizational, and system-level barriers to peer integration and retention.
3. Analyze financial, administrative, and regulatory processes affecting peer service delivery.
4. Develop actionable recommendations to strengthen and sustain Florida's peer workforce within DCF-funded systems.

Secondary data revealed that engagement with CRPSs is associated with Medication Assisted Treatment (MAT) service receipt and successful treatment completion. Preliminary analyses highlight that the flexibility of CRPS to connect with individuals in community and across settings may have meaningful implications for promoting treatment engagement.

Across interviews, peers and peer supervisors consistently described a unique ability to

build trust, support motivation, and bridge gaps that traditional clinical roles do not always address. Despite these strengths, the evaluation identified several structural and operational challenges that limit the full potential of the peer workforce. Although most peers generally reported clarity regarding their roles and responsibilities, instances of unclear boundaries and role drift were noted as threats to the integrity of peer support practice. Notably, supervision provided by individuals with lived experience and formal training in peer support seemed to mitigate these risks. Such supervisors were more likely to safeguard role clarity, reinforce the integrity of the peer role, and cultivate work environments in which peers felt respected and professionally supported.

The evaluation also identified barriers to workforce entry. Florida's background screening and exemption process, while acknowledged as necessary and important, was frequently described by applicants as administratively cumbersome and, at times, financially burdensome. Although most exemption requests were ultimately approved, the length and complexity of the exemption process may discourage otherwise qualified individuals with lived experience from pursuing CRPS certification and employment.

Concerns about the sustainability of peer roles also emerged as a consistent theme. Peers reported a strong sense of purpose and deep commitment to their work yet also described feeling undervalued and strained by comparatively low compensation and inconsistent opportunities for career advancement. Participants further identified a need for continued training, particularly in risk reduction, de-escalation and crisis intervention, self-care, and boundary setting, to ensure peers remain adequately prepared to support individuals with complex and evolving recovery needs.

System-level challenges further complicated sustainability. Documentation requirements, limited use of Medicaid reimbursement mechanisms, and restrictions on which peer services may be billed and under what conditions collectively constrain the financial viability and expansion of peer roles.

Overall, these findings highlight opportunities to strengthen Florida’s peer workforce, and several broad recommendations emerged:

1. **Enhance Workforce Integration and Role Clarity**. Peers and provider organizations would benefit from greater consistency in how the CRPS role is defined and operationalized across settings. This includes reinforcing standardized peer responsibilities and providing practical guidance to organizations on how to effectively embed peers across settings and within multidisciplinary teams. A coordinated strategy for role education targeting leadership, supervisors, and clinical staff would help ensure peers are utilized as intended and reduce the risk for role drift.

2. **Expand CRPS Training and Professional Advancement Infrastructure**. While certification establishes a foundation, peers require ongoing and advanced training to navigate the complexities and demands of service delivery. To maintain peer role competency and strengthen long-term sustainability, advanced continuing education opportunities should be prioritized. In addition, opportunities for peer role advancement should be developed with parallel advances in compensation. Compensation benchmarks for provider organizations and managing entities should align with the professionalization of the peer role and be structured within the context of the broader behavioral health workforce to improve recruitment, retention, and workforce stability among peer specialists

3. **Streamline Administrative Processes to Increase Workforce Accessibility**. Particular attention should be given to Florida's background screening and exemption process. Opportunities exist to improve transparency, reduce processing delays, and minimize financial burden while maintaining appropriate safety standards. Incorporating recovery-oriented practices into administrative procedures would help reduce attrition among qualified applicants with lived experience.

4. **Strengthen and Diversify Funding and Infrastructures Supports**. Sustainable peer services require more robust and flexible financial mechanisms. Enhancing provider readiness on Medicaid billing and offering training on documentation and billing requirements would increase financial viability. Additionally, offering technical assistance such as grant writing, funding strategies, and data reporting would strengthen organizational capacity to support and sustain peer roles across a variety of funding streams.

Overall, this evaluation demonstrates that CRPSs are an important component of Florida's behavioral health workforce. Strengthening this workforce, however, requires coordinated, system-level action. Maintaining appropriate role boundaries, expanding access to training and supervision, streamlining administrative processes, and diversifying and stabilizing funding structures are all critical to long-term sustainability. Together, these efforts will help ensure that peers are fully integrated, appropriately compensated, and professionally well-supported, positioning CRPSs to continue contributing to a more resilient, effective, and recovery-oriented behavioral health system across Florida.

# INTRODUCTION

## Overview

Following Specific Appropriation 359 of the 2025-2026 General Appropriations Act and at the request of the Department of Children and Families (DCF) Office of Substance Abuse and Mental Health (SAMH), this commissioned evaluation was designed to examine the effectiveness and barriers in the use of peer specialists within Florida's recovery-oriented systems of care (ROSC) for opioid-related and other substance use disorders. More specifically, the objectives of this evaluation were to:

**Objective 1.** Examine the effectiveness of recovery peer specialists supporting Floridians affected by substance use.

**Objective 2.** Identify individual/workforce-related, institutional, legal, and procedural barriers to integrating and retaining peer specialists in Florida ROSCs. More specifically:

> **2a.** An exploration of specific barriers such as training, role clarity, supervision, employment condition, including stigma; and,
>
> **2b.** An examination of reasons for exemption from disqualification.

**Objective 3.** Examine peer models across ROSCs and associated funding models within Florida and across U.S. states.

**Objective 4.** Provide data-driven strategy, programming, and policy/administrative rule recommendations to advance integration and promote sustainability of Florida's recovery peer specialists for opioid and other substance use disorders, with specific recommendations related to:

> **4a.** Effective peer models.
>
> **4b.** Strategies to improve peer integration across coordinated systems, such as hospitals, criminal justice and across Florida, including rural communities.
>
> **4c.** Strategies to improve the peer workforce pipeline, including training, employment processes, certification and exemption from disqualification policies and operating procedures.
>
> **4d.** Sustainable funding models.

# Background

## *Substance Use Disorders: Prevalence and Impact*

According to 2024 findings of the National Survey on Drug Use and Health (NSDUH), approximately 46.3 million adults aged 18 years and older in the United States (U.S.) experienced a past-year substance use disorder (SUD)[1]. This includes 27.1 million adults with past-year Alcohol Use Disorder, 19.4 million with past-year Marijuana Use Disorder, 4.1 million with past-year Stimulant Use Disorder, and 4.6 million with past-year Opioid Use Disorder[2]. The opioid epidemic specifically has had far-reaching social and economic consequences in the U.S. for nearly four decades[3], including devastating loss of life, increased healthcare costs, strain on substance use treatment and recovery systems, decreased workforce productivity, and significant harm to families and child welfare[4,5].

In 2023, an estimated 110,037 drug overdose deaths occurred in the U.S., with approximately 83,140 of those deaths, or 76 percent, involving opioids[6]. This marked a three to four percent decrease in opioid-involved overdose deaths compared to 2022, representing the first decline recorded since 2018, and preliminary data indicate a continued downward trend through 2024[6,7]. Experts have suggested several contributing factors for the decline in overdose-related deaths, including the increased availability of naloxone, fentanyl test strips, Medication for Opioid Use Disorder (MOUD), and risk reduction programs, as well as broader public health efforts to integrate recovery peer support services across the continuum of care[8,9,10].

In Florida, over 2.9 million, or 16.4 percent, of adults aged 18 and over experienced a past-year SUD from 2022 through 2023 according to NSDUH published findings[11,12]. More specifically, an estimated 10.2 percent of Florida adults met diagnostic criteria for a past-year Alcohol Use Disorder and 8.8 percent for a past-year substance use disorder, 2.1 percent of which were Opioid Use Disorder[12]. Among past-year SUDs, opioid use remains a particularly urgent concern in the state due to its potential for overdose and mortality. As with the larger U.S., Florida continues to experience a significant burden from the opioid crisis, though recent data suggest some stabilization in opioid overdose mortality consistent with national trends. Preliminary 2024 data from the Florida Department of Law Enforcement (FDLE) indicate a 14 percent decrease in all-drug overdose deaths and a 32 percent decrease in opioid-caused overdose deaths[13]. These encouraging declines underscore the importance of sustaining and evaluating evidence-based overdose prevention strategies to ensure continued progress in reducing substance-related risks.

## *Florida's Response*

Florida has implemented a multipronged approach to address the opioid crisis by integrating prevention, treatment, and risk reduction/safety-oriented strategies. Key efforts have included the establishment of the state's Prescription Drug Monitoring Program (PDMP), expanded government funding for evidence-based substance use treatment services, and increased availability of naloxone for first responders and community members who are at risk of experiencing or witnessing an overdose. In recent years Florida has launched several additional statewide initiatives, a central component of which has been the elevation of recovery peer specialists as integral members of the behavioral health workforce and ROSCs.

Recovery peer specialists are individuals with lived experience of substance use and/or mental health conditions who are uniquely positioned to provide emotional support, system navigation, and guidance to those seeking recovery[14]. Florida's DCF-supported recovery peer model is grounded in the Substance Abuse and Mental Health Services Administration's (SAMHSA) guiding principles of recovery, core ethical standards, and individualized recovery and wellness[15,16,17,18]. Recovery peer specialists engage participants in an assessment of recovery capital and collaborative recovery and wellness planning, providing emotional, informational, affiliation, and instrumental supports. Through this service-oriented role, they help individuals strengthen recovery across key domains of health, purpose, home, and community[15,16,17,18].

Key Florida recovery peer specialist initiatives include:

- Development and implementation of best practice standards for Managing Entities (Guidance Document #35 *Recovery Management Practices*) to transform delivery of care to one that focuses on sustainable wellness and recovery.

- Allocation of non-recurring funds to support Certified Recovery Peer Specialists positions as part of a broader strategy to expand the peer workforce and enhance services for individuals affected by substance use. This effort emphasizes placing trained peers in diverse settings where their lived experience can provide meaningful, practical support.

- Financial assistance for certification applications, examinations, and renewals, helping reduce barriers for individuals pursuing or maintaining CRPS credentials.

- Expansion of Recovery Community Organizations, which employ CRPSs to provide individualized recovery support and strengthen local recovery networks[19].

- Florida's Coordinated Opioid Recovery (CORE) Network, which connects individuals with SUD, prioritizing opioid use, with first responders, hospitals, treatment providers, and recovery services to ensure comprehensive, long-term care. The CORE Network also integrates CRPSs to facilitate warm handoffs and continuous engagement across multiple points of care[20].

## *Effectiveness and Use of Recovery Peer Specialists*

### Literature Review

A review of the empirical literature supports the effectiveness of peer support services in reducing substance use, increasing treatment engagement, and improving participants' mental health and social support[21,22,23]. Some of the strongest empirical support for CRPSs, however, lies in their ability to facilitate the initiation of and engagement in MOUD, which is widely regarded as the gold-standard treatment for opioid use disorder[22,24]. Despite the growing evidence base, important knowledge gaps remain.

For example, few studies have examined the impact of peer support on treatment retention, sustained recovery, defined as one to five years, and long-term recovery stability, defined as five or more years, which are critical to reducing return to use and overdose risk. Moreover, most existing research has focused on peer-delivered services within substance use treatment and broader healthcare settings, leaving limited understanding of their effectiveness in community-based, child welfare, and criminal justice settings where peers are increasingly present[25,26].

Within the literature, challenges to the effective implementation and sustainability of peer services have been identified at multiple levels including within individuals, organizations, and systems. At the individual level, peers may experience role ambiguity, burnout, and inconsistent supervision models[21,23]. At the organizational level, challenges include inconsistent hiring processes and role definitions, limited career advancement opportunities, low pay, and stigma from non-peer staff[25,27,28]. At the systems level, obstacles include complex certification and reimbursement processes, as well as insufficient data infrastructure to track peer outcomes[27,29]. In addition to these multi-level barriers, a lack of stable, recurring funding has been identified as posing a major challenge. Many organizations rely primarily on contracts and/or grants and short-term funding rather than sustainable revenue streams such as insurance reimbursement to fund peer services[27,30]. Gaps in training, continuing education, and professional development opportunities may further hinder workforce sustainability and the ongoing quality improvement of peer services[27,31].

### Florida

As described, Florida is committed to and has made significant investments in mitigating the substance use disorder epidemic in the state, promoting recovery and providing essential, unparalleled supports by trained and certified recovery peer specialists. Encouragingly, as investments and available programs have expanded, so has the peer workforce. Specifically, there has been a significant increase in the availability of CRPSs in Florida, with the annual number of newly CRPSs rising from 164 in 2019 to 476 in 2024 according to the Florida Certification Board, Florida's appointed certifying body for recovery peer specialists[32]. This represents a nearly threefold increase.

While the effectiveness and barriers to use of recovery peer specialists have been documented in the literature more broadly, the effectiveness and utilization of certified recovery peer specialists across ROSCs have not been examined in Florida to date. Given the expansion of the workforce and State programming in recent years, and in the interest of workforce wellbeing, program effectiveness and continuous quality improvement and a return on investment for the state, a comprehensive, statewide analysis is essential at this juncture. A literature review matrix is included in Appendix 1, Table 1.

## Current Study

This commissioned mixed-methods evaluation provides a comprehensive assessment of Florida's recovery peer specialist workforce among organizations funded through Florida Managing Entities (MEs) from DCF funds. The evaluation focuses on assessing the perceived effectiveness of CRPSs in supporting recovery-related outcomes and identifying barriers to the integration and retention of peer specialists as essential components of the state's substance use and recovery continuum of care.

A multi-method approach, including an empirical literature review, analysis of secondary DCF data, a mixed-methods survey, qualitative survey responses and semi-structured interviews, and analysis of relevant policies and administrative rules in Florida and across the United States was employed. Findings were then triangulated to identify strengths and barriers and inform actionable recommendations to replicate and expand successes, mitigate barriers identified, strengthen workforce sustainability, and enhance the effectiveness and integration of recovery peer specialists across Florida's substance use treatment and recovery-oriented systems of care.

# METHODS

This section outlines the methodology used to address study objectives. The research employed a comprehensive, mixed-methods approach that included a national and state-level review of processes and policies, secondary analysis of Florida-specific program and procedural data, and original research conducted by the evaluation team. The original research component consisted of a mixed-method study incorporating self-report questionnaires and open-ended response items, as well as qualitative interviews. The methods are presented from a national macrolevel perspective to a local-level focus, including qualitative responses from CRPSs and other key program personnel.

## Process and Policy Review

### *Background Screening and Exemption*

#### National

A national landscape analysis of criminal background screening policies for recovery peer specialists was conducted by national subject matter experts. Application requirements, behavioral health and human-service licensing and certification statutes, administrative codes, criminal history and registry requirements, and state waiver/exemption policies were reviewed across 50 states, along the following points of analysis:

1. Does peer certification require a background check?
2. Is Level 2* background clearance required for employment in Medicaid-licensed providers/facilities?
   **A Level 2 background screening refers to a fingerprint-verified, security background investigation of state and federal criminal record history, as well as sexual offender registries, to identify the presence of any disqualifying offenses.*
3. Are automatic disqualifying offenses listed publicly?
4. Is an exemption, variance, or waiver mechanism available?

#### Florida

Relevant Florida Statutes (F.S.), including F.S. 397.321[33], FS. 397.4073[34], F.S. 397.417[35], and F.S.,435.07[36], were reviewed, as were the “CRPS Standards, Requirements, and Application Guide[37],” “CRPS-Provisional/Upgrade Standards, Requirements, and Application Guide[38]” “Florida Certification Board Criminal History

Policy[39]," "FCB Code of Ethical and Professional Conduct[40]," and the Department of Children and Families "FAQ for Exemptions[41]" and "FAQ for Peers[42]," all published on their respective websites. The Background Screening Program at the Florida Department of Children and Families and personnel of the FCB provided principal investigators education and clarification on processes and operating procedures within and between these two agencies as it relates to certification and exemption from disqualification.

For the purposes of this evaluation, Florida policies and operating procedures related to background screening requirements for peer certification, criminal history offenses that would disqualify an individual from obtaining certification, and allowable exemptions from recovery peer certification disqualification were compared against other U.S. states, as well as the SAMHSA "National Model Standard for Peer Support Certification[43].

## *Funding Models*

### National

A national landscape analysis of funding mechanisms was conducted by national subject matter experts. This included a review of existing cross-state policy overviews in the literature conducted by reputable and policy-establishing, informing researchers and national organizations, including the National Conference of State Legislatures, Administration for Community Living, SAMHSA, and Centers for Medicare & Medicaid Services, as well as an examination of peer recovery services funding sources across 27 U.S. states. A 50-state scan of Medicaid coverage for recovery peer support services, including limits and requirements, was also conducted.

### Florida

Florida legislative and publicly available DCF documents were reviewed to examine state appropriations and funding mechanisms for substance use disorder services, including the integration of recovery peer specialists. Specific documents include but are not limited to: Fiscal Year (FY) 2025–2026 General Appropriations (Ch. 2025-198)[44]; Floridians First: FY 2026–2027 Budget Proposal[45], Florida Department of Children and Families Office of Substance Abuse and Mental Health Triennial Master Plan Annual Update[46]; Florida Department of Children and Families Statewide Council on Opioid Abatement Annual Report[47]; Behavioral Health Managing Entities Financial and Operational Audits Report Summary[48]. Florida Agency for Health Care Administration (AHCA) rules for service coverage and reimbursement were also examined as an independent but related health services funding source[49].

Florida-specific health policy and funding mechanisms were examined relative to other U.S. states and national findings.

## Secondary Data Analysis

This analysis used de-identified administrative data from the Financial and Services Accountability Management System (FASAMS), DCF's data system, to evaluate whether CRPS involvement supports individual service recipient engagement in formal clinical treatment and contributes to successful completion of treatment. The primary intent was to examine the reach and impact of CRPSs within DCF-funded substance use and co-occurring substance use and mental health programs. Because FASAMS records each service encounter individually, the data allow assessment of service intensity, engagement over time, and treatment episode outcomes, which provides an observable proxy for program effectiveness in the absence of standardized clinical outcome measures.

The secondary data analysis addressed three primary research questions:

1. Is CRPS involvement associated with a higher likelihood of receiving Medication Assisted Treatment?

2. Is CRPS involvement associated with greater intensity and longer duration of participation among service recipients aged 18 and older?

3. Is CRPS involvement associated with a higher likelihood of successfully completing a treatment episode of care?

### *Data Collection*

De-identified behavioral health data were provided by DCF for fiscal years 2022–2023, 2023–2024, and 2024–2025. The three-year timeframe ensured a sufficiently large and stable sample, captured complete treatment episodes from admission through discharge, and aligned with state fiscal year reporting periods. Data included records of service encounters for DCF-funded substance use and co-occurring programs. Clinical treatment services were defined as interventions conventionally delivered by licensed or other credentialed clinical staff, including counseling, therapy, case management, and other provider-led services intended to address substance use and co-occurring mental health conditions. Because FASAMS records each service encounter separately, individuals may appear multiple times in the dataset. To ensure the analysis captured meaningful treatment outcomes rather than isolated service events, data were aggregated either at the individual level or the treatment episode level, depending on the outcome of interest.

## *Outcome Variables*

**Treatment Engagement.** For this analysis, effectiveness was operationalized using sustained engagement in clinical treatment services as a proxy. This operationalization reflects the widely accepted view within behavioral health and peer support practice that consistent participation in treatment is a necessary precursor to positive clinical outcomes. Because CRPSs are non-clinical providers, this measure captures whether peer involvement supports individuals in accessing and maintaining consistent participation in formal clinical services. Engagement in clinical treatment provides the most observable and measurable indicator of program impact available within administrative data.

Treatment engagement captured both intensity and duration of clinical treatment participation. Intensity was defined as the total number of clinical treatment services received per service recipient during the three-year period, and duration was defined as the number of distinct months in which an individual received at least one clinical treatment service. Data were aggregated at the individual service recipient level to measure overall participation in care over time. An additional yes-no variable specifically reflecting individual engagement in MAT services was also examined.

**Successful Treatment Completion.** Successful completion was measured at the treatment episode level. Each episode was coded in FASAMS as either “successfully completed treatment” or not. This designation reflects administrative closure by the provider and does not independently verify long-term recovery or post-discharge outcomes. Aggregating data by individual admission identifiers ensured that analyses captured outcomes for the full course of care per service recipient, rather than individual service events in which individual recipients may experience more than one service event.

## *Other Key Variables*

**Demographic Characteristics.** Demographics were captured at the individual level and included age, gender, and race/ethnicity. These characteristics allowed the analysis to describe the population receiving DCF-funded substance use and co-occurring services and to examine whether service recipient-level differences influenced engagement or treatment completion.

**Treatment Location.** Treatment location was recorded at both the individual service recipient and treatment service levels. This variable enabled assessment of how the service setting influenced engagement patterns. Capturing location information at multiple levels also supported analyses of setting-specific effects of CRPS involvement.

## *Data Analysis*

### Clinical Treatment Service Data

Analyses were conducted using the Statistical Package for Social Sciences (SPSS) version 31. Service-event–level data were aggregated to the individual level to support analyses of engagement outcomes, with each individual represented by a single observation reflecting their overall service history. Individual-level engagement measures included:

- Total service utilization recorded as number of documented service events;
- Duration of engagement recorded as months between first and last observed service event); and
- MAT engagement recorded with a yes or no response.

Completed treatment episode data were aggregated to the individual admissions level to support analysis of successful completion of treatment.

Please note, because Recovery Support services provided to individuals and groups are non-clinical in nature, delivered by CRPSs, and served as the exposure of interest, recovery support service events were excluded from clinical treatment service counts. Including peer-delivered services in the denominator would have increased service counts and duration among CRPS-involved service recipients and misconstrued the engagement measures. Therefore, analyses of clinical treatment utilization and duration were based solely on clinical treatment services. Clinical treatment engagement outcomes were analyzed at the service recipient-level, with each service recipient represented by a single observation. Service recipient-level engagement measures included total number of clinical treatment services received during the study period and total months engaged in clinical treatment services. Months engaged were defined as the number of months between July 2022 and June 2025 in which a service recipient received at least one clinical treatment service.

Engagement outcomes were compared between CRPS-involved and non-CRPS-involved service recipients. Additional analyses examined duration and intensity of clinical treatment engagement among CRPS-involved service recipients by treatment setting category, including acute care settings, medical hospital settings, jail/prison, community or recipient home settings, provider premises, and service recipients receiving services across multiple settings, as well as MAT engagement.

As engagement measures were positively skewed and not normally distributed,

medians and interquartile ranges were used to summarize service utilization and duration. Group comparisons between CRPS-involved and non-CRPS-involved service recipients were conducted using nonparametric methods. Mann–Whitney U tests were used to compare continuous engagement measures. Statistical significance was established at $\alpha = .05$.

### Discharge Data

For the discharge analysis, discharge data were examined at the treatment episode level. The unit of analysis was a unique admission with a corresponding discharge ($N$ = 103,303). As multiple service records may occur within a single admission, service-level records were aggregated to the treatment episode level prior to analysis. Some individuals contributed more than one treatment episode during the study period.

Descriptive statistics and chi-square tests were used to examine the unadjusted association between CRPS involvement and successful treatment completion, or discharge. Logistic regression models were then estimated to examine both the unadjusted and adjusted associations between CRPS involvement and successful discharge. The multivariable model adjusted for gender, race, ethnicity, treatment location, and total sum of services received during the episode. Treatment locale categories were collapsed into clinically meaningful groups to improve model stability and reduce sparse cells. Adjusted odds ratios (ORs) with 95 percent confidence intervals were calculated to estimate the magnitude and precision of associations. Statistical significance was established $\alpha = .05$.

## Sample Characteristics

### CRPS-Involved

Appendix 2, Table 1 shows the characteristics of CRPS-involved treatment service events, including a total of 470,554 peer-led services representing the program areas of Adult Substance Abuse ($n$ = 342,226) and Adult Substance Abuse and Mental Health ($n$ = 128,328). As individual service recipients may contribute to more than one service event, there were 24,239 unique service recipients included in the analytic sample of CRPS-involved clinical treatment services (see Appendix 2, Table 2). Among unique CRPS service recipients, most were male at 54.1 percent, White at 72.1 percent, non-Hispanic at 84.0 percent, and between 30 and 39 years of age at 37.4 percent. The majority of CRPS-involved service recipients, 87.9 percent, were not enrolled in MAT at the date of the first clinical treatment service. CRPS-involved service recipients received an average of 19.4 services during the study period.

### Non-CRPS

A total of 438,606 non-peer-involved service events representing the program areas of Adult Substance Abuse (*n* = 339,766) and Adult Substance Abuse and Mental Health (*n* = 98,804) were included in the final comparison sample. Appendix 2, Table 3 shows the characteristics of non-CRPS involved treatment service events. The service recipient characteristics (see appendix 2 table 4) with no CRPS involved in treatment services included a random sample of approximately 30 percent of the total service recipients without CRPS involvement during the study period. As individual service recipients may contribute to more than one service event, there were 32,175 unique service recipients represented in the analytic sample. Similar to CRPS recipients, individuals without CRPS involvement were predominantly male at 60.4 percent, White at 67.8 percent, non-Hispanic at 81.3 percent, and between 30 and 39 years of age at 33.9 percent. Medication-assisted treatment enrollment was also relatively low among non-CRPS service recipients at 8.7 percent. Non-CRPS involved service recipients utilized an average of 13.6 services during the study period.

### Discharge

The analytical sample represented service recipients with completed treatment episodes defined as completed admission and discharge. There were 256,266 service records amongst this sample. As multiple service records may occur within a single treatment episode, individual service recipients may contribute more than one completed episode. A total of 102,414 unique individuals with completed treatment episodes of care were included in the sample.

## *DCF Disqualification from Exemption Data*

Data was requested from DCF for FY 2022 – 2023, 2023 – 2024, and 2024 – 2025, including number of exemptions from recovery peer certification disqualification requests, total number denied and number denied by denial reason, number of pending requests at fiscal year-end, number of appeals requested, and number of appeals with decision of disqualification from Exemption. Descriptive statistics were examined in the aggregate, for each fiscal year, and for year-over-year comparisons.

## *Managing Entity Expenditure Data*

ME service expenditure data was provided by DCF for FY 2022–2023, 2023–2024, and 2024–2025, allowing the examination of DCF-funded recovery support services over a three-year period. The dataset included information pertaining to:

- Service or programs such as Recovery Support services.
- Payment methods such as fee for service or capitated.
- Payment rate.
- Payment units defined as direct staff hour in minutes.
- Total expenditure for each provider organization contracted with a given ME.

Descriptive statistics were calculated allowing these variables to be examined in the aggregate, across ME groups and services, such as Individual Recovery Support services, Group Recovery Support Services, and over time.

It is important to note that recovery support services could not be isolated in this dataset to those services being delivered by CRPS personnel or specifically to Substance Abuse or Substance Abuse and Mental Health programs. As such, results reflect recovery support services across both DCF mental health, substance abuse, and co-occurring mental health and substance abuse programs.

## Mixed-Method Survey

The mixed-method survey component utilized an exploratory, cross-sectional design to characterize the following information among CRPSs, provisionally certified peer specialists (CRPS-P), and peer supervisors:

- Workforce demographics
- Training and certification experiences
- Organizational context
- Burnout
- Perceived effectiveness
- Intent to leave

## *Sampling Procedures*

### Eligibility Criteria

This evaluation was conducted statewide in Florida and focused on peer services delivered within programs funded by DCF. The survey sampling frame targeted CRPSs, CRPS-P, and supervisors overseeing peer staff. Specific eligibility criteria included:

- Currently working with individuals with substance use–related needs in the state of Florida.

- Active CRPS or CRPS-P credential, for the peer specialist sample, or actively supervising individuals working in recovery peer specialist roles, for the supervisor sample. Supervisors were not required to hold peer certification.

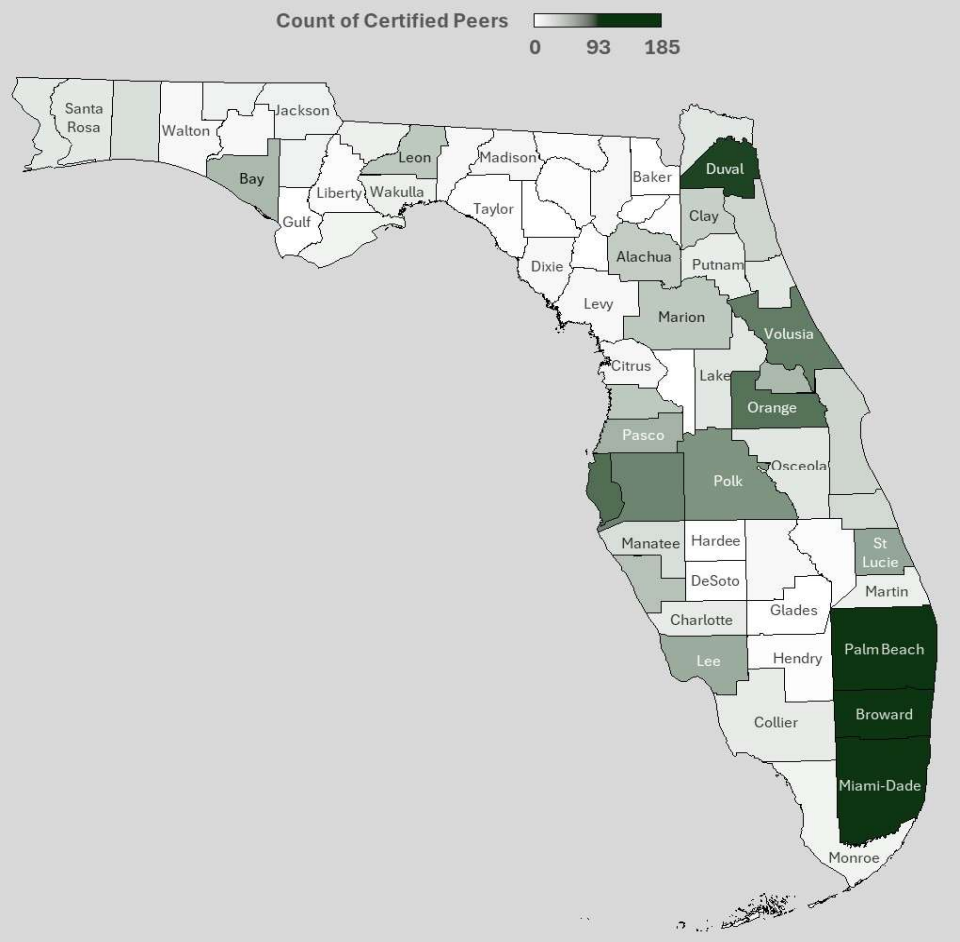
### Recruitment

Prior to formal recruitment, the principal investigators delivered informational presentations to the Florida Association of Managing Entities and several regional behavioral health coalitions, like Live Tampa Bay and Hillsborough Recovery Coalition, to introduce the study objectives, encourage cross-system engagement, and facilitate access to diverse provider organizations. Additionally, the evaluation team obtained counts of certified peers by county from the state certifying authority. These county-level distributions were used to inform and weight recruitment targets to ensure that the final sample approximated the geographic distribution of the CRPS workforce. Heatmaps depicting the density of certified peers by county were developed to guide targeted recruitment outreach. This data-informed approach helped avoid over-representation of urban regions and strengthened statewide representativeness (see Figure 1).

Survey recruitment for this statewide evaluation began on Nov. 10, 2025, and ended on Dec. 9, 2025. Invitations were distributed via email to leadership and designated contacts within all seven Managing Entities and 21 Recovery Community Organizations identified through DCF SAMH. Additional invitations were disseminated through the evaluation team's and project consultants' professional networks in Florida including the National Alliance on Mental Illness (NAMI) Florida, various Florida Federally Qualified Health Centers and the Mental Health Task Force of Northwest Florida.

To expand reach beyond formal networks, regional nonprofit organizations and partner agencies shared the survey through organizational listservs and newsletters. Snowball sampling was also encouraged, in which participants were invited to forward a survey link to colleagues working in peer services across the state. This multi-pronged recruitment strategy was intentionally designed to capture variation across geographic regions, employer types, and service settings. There was an incentive to participate that included a $25.00 Amazon gift card.

**Figure 1. Distribution of Certified Peers by County**




*Note.* Baker, Desoto, Gilchrist, Glades, Gulf, Hardee, Lafayette, Sumter, and Union counties did not have any CRPS. Appendix 2 Table 5 provides the raw count.

## *Survey Development*

The survey was designed to assess the perspectives, experiences, and workforce needs of CRPSs and their supervisors across Florida. Survey development followed an iterative and community-informed process that involved a literature review, CRPS feedback and stakeholder consultation, internal review, and pilot testing.

### Literature Review and Stakeholder Engagement

The evaluation team conducted a comprehensive literature review to identify key constructs relevant to the peer workforce including burnout, recovery capital, organizational climate, and intent to leave. Peer-reviewed studies, federal workforce reports, and state-level evaluations informed construct selection to ensure alignment

with contemporary evidence on peer specialist effectiveness and behavioral health workforce challenges.

The evaluation team consulted with project-affiliated subject matter experts and drew discussions with professional networks across Florida's behavioral health system(s) of care. These consultations helped identify context-specific considerations, clarify terminology, and refine item phrasing to ensure relevance for peers and supervisors. Consultants included individuals with direct experience in peer services, workforce training, and Managing Entity operations, which provided diverse perspectives on workforce needs and challenges.

### Internal Review and Pilot Testing

The evaluation team engaged in multiple cycles of internal review to assess content validity, clarity, and interpretability. Items were revised to improve alignment with constructs, reduce ambiguity, and ensure consistent response options. Decision rules were established regarding item phrasing: peer specialists responded regarding their own experiences from a first-person perspective, while supervisors were instructed to respond based on their perceptions of the peer workforce in general rather than only the peers they directly supervise, unless otherwise specified. In select cases, the same phrasing was used across both groups to ensure comparability across roles such as items assessing intent to leave. Open-ended survey questions were developed in parallel to quantitative survey items designed to capture nuanced perspectives and emergent themes not fully reflected in structured response options. These open-ended items were developed through an iterative process informed by the literature review, stakeholder input, and pilot testing, with revisions made to improve clarity and relevance.

Feedback from consultant subject matter experts was incorporated throughout the survey development process. Specifically, the draft survey was internally pilot tested with a small group of CRPSs and CRPS supervisors who represented the intended stakeholder groups. Pilot testing was used to assess item comprehension and relevance, survey length, skip logic, and technical functionality. Feedback informed the final set of revisions before full survey deployment.

### Final Survey

The final survey was imported to Qualtrics for dissemination, which allowed secure data collection, skip logic, and role-specific question routing. The survey employed role-based branching logic to ensure that peers and supervisors received parallel items tailored to their respective roles. Responses were measured through a 5-point Likert scale, ranging from 1-strongly disagree to 5-strongly agree, unless otherwise noted.

Peers responded regarding their own experiences in the first person, while supervisors responded regarding the peer workforce in the third person. This design permitted direct comparison across respondent roles while preserving conceptual and measurement consistency within each scale. Table 1 summarizes the survey domains, sample items, number of items per scale, and source materials informing each domain.

**Table 1: Survey Scale Description**

| Domain | Sample Items | | Items | Source** |
|---|---|---|---|---|
| | Peer | Supervisor* | | |
| **Intent to Leave** | I am likely to leave this (my) profession in the next year. | *Same phrasing* | 3 | Evaluation Team |
| **Peer Effectiveness** | I feel confident in my ability to make a positive impact through my peer work. | I feel confident in **peer specialists'** ability to make a positive impact through **their** peer work. | 3 | Evaluation Team |
| **Recovery Capital** | I know that my life has a purpose. | *N/A* | 12 | Whitesock et al. (2018) |
| **Role Clarity** | I know what is expected of me in my job. | **They** know what is expected of **them** in their job. | 3 | Bowling et al. (2017) |
| **Burnout** | I feel emotionally drained from my work. | **They** are emotionally drained by **their** work. | 3 | Maslach et al. (1997) |
| **Workload** | The amount of work I am expected to do is more than I can handle. | The amount of work **they're** expected to do is more than **they** can handle. | 3 | O'Brien-Pallas et al. (1997) |
| **Work-life Balance** | My personal life suffers because of my work. | **Their** personal lives suffer because of **their** work. | 3 | Hayman (2005) |
| **Occupational Self-Efficacy** | When I am confronted with a problem in my job, I can usually find several solutions. | When confronted with a problem in **their** job, they are able to find several solutions. | 3 | Schyns & von Collani (2002) |
| **Lived Experience Climate** | I am comfortable with how peers are treated by my employer. | *Same phrasing* | 8 | Jones et al. (2020) |

| | | | | |
|---|---|---|---|---|
| **Organizational Climate** | My organization recognizes that peer support specialists are uniquely qualified through their lived experience/expertise of recovery. | *Same phrasing* | 5 | PeerTAC (n.d) |
| **Peer Status and Influence** | Peer staff play a unique and important role in substance use services. | *Same phrasing* | 5 | Jones et al. (2020) |
| **Supervisor Support** | My current/most recent supervisor (or manager) provides opportunities for me to develop new skills within my current position. | **Peer supervisors** provide opportunities for peer specialists to develop new skills within their current positions. | 7 | Jones et al. (2020) |
| **Supervisor Working Alliance** | I feel comfortable working with my supervisor. | **Peer specialists** are comfortable working with their supervisors. | 3 | Efstation et al. (1990) |
| **Advancement** | I see a pathway for advancement in my role at my organization. | I believe there is a clear pathway for advancement for the **peers I supervise** at my organization. | 4 | Evaluation Team |
| **Training** | I receive sufficient ongoing training to maintain or improve my skills. | **Peer specialists** receive sufficient ongoing training to maintain or improve **their** skills. | 3 | Evaluation Team |
| **Exemption Process** | Exemption applications are processed in a timely manner. | *Same phrasing* | 3 | Evaluation Team |
| **Certification Process** | The Florida CRPS training curriculum reflected the realities of peer work. | *Same phrasing* | 4 | Tate et al. (2022) |

## *Measures*

### Intent to Leave

The Intent to Leave scale measured both peer specialists' and supervisors' likelihood of leaving their current position or profession. The scale was

developed by the evaluation team and consisted of three items:

1. “How likely are you to seek a new employment opportunity in the next 6 months?”
2. “I intend to stay with my current employer/practice for at least a year” (reverse-scored for analysis).
3. “I am likely to leave this (my) profession in the next year.”

Items were rated on a 5-point Likert-type scale ranging from 1-extremely unlikely to 5-extremely likely, with higher scores indicating greater intent to leave. Internal consistency was acceptable for peers (Cronbach’s α = .75), supervisors (Cronbach’s α = .87), and the combined peer-supervisor Intent to Leave measure (Cronbach’s α of .78).

### Peer Effectiveness

This Peer Effectiveness scale assessed peer specialists’ and supervisors’ perceptions of the impact of peer support work. Peers responded, in first person, regarding their own role, while supervisors responded, in third person, regarding the peer staff they supervise. The scale was developed by the evaluation team and included three items:

1. “I believe my role contributes to positive outcomes”.
2. “I feel confident in my ability to make a positive impact”.
3. “My role provides unique support complementing clinical services”.

Supervisor items were phrased to reflect their observations of peer staff, for example “Peer specialists provide unique support complementing clinical services”. Responses were recorded on a 5-point Likert-type scale ranging from 1-Strongly Disagree to 5-Strongly Agree, with higher scores indicating greater perceived effectiveness. Internal consistency was acceptable for peers (Cronbach’s α = .89), supervisors (Cronbach’s α = .76), and the combined peer-supervisor measure (Cronbach’s α = .88).

### Recovery Capital

Recovery Capital was assessed among peer specialists to capture the personal, social, and structural resources that support long-term recovery and functioning in the workforce. Recovery capital was examined as a theoretically relevant construct within recovery-oriented systems of care and as a factor that may influence resilience, occupational functioning, and workforce sustainability. In this context, it was conceptualized as relevant to role functioning rather than as a

proxy for personal recovery status or program compliance.

The scale was informed by prior conceptualizations of recovery capital and adapted from Whitesock and colleagues[50]. Twelve items were selected, assessing domains such as employment and financial stability, access to healthcare and transportation, recovery-supportive living environments, ongoing engagement in recovery activities, social support, and personal meaning. Sample items included: “I have a stable job that I enjoy and that provides for my basic necessities,” “I live in an environment free from alcohol and other drugs,” and “I know that my life has a purpose.” Responses were recorded on a 5-point Likert-type scale ranging from 1-strongly disagree to 5-strongly agree, with higher scores indicating higher recovery capital. Internal consistency of the scale was strong in the peer sample (Cronbach’s α = .88). This scale was administered only to peer specialists.

### Role Clarity

Role Clarity was assessed using a three-item scale informed by prior work on role ambiguity and clarity in behavioral health and human service settings[51]. Items assessed respondents’ understanding of job expectations, clarity of duties, and scope of responsibilities. Peer specialists responded from a first-person perspective, for example, “I know what is expected of me in my job,” while supervisors responded from a third-person perspective regarding peer staff, for example, “They know what is expected of them in their job”. Items were rated on a 5-point Likert-type scale ranging from strongly disagree to strongly agree. The scale demonstrated acceptable internal consistency for peers (Cronbach’s α = .91), supervisors (Cronbach’s α = .83), and the combined peer-supervisor measure (Cronbach’s α = .89).

### Burnout

Burnout was assessed using a three-item scale adapted from the Maslach Burnout Inventory[52]. Items captured feelings of emotional depletion and exhaustion related to work demands. Peer specialists responded from a first-person perspective, for example, “I feel emotionally drained from my work”, whereas supervisors responded from a third-person perspective reflecting their perceptions of peer staff, for example, “They are emotionally drained by their work”. Responses were recorded on a 5-point Likert-type scale ranging from 1-Strongly Disagree to 5-Strongly Agree, with higher scores indicating greater burnout. Internal consistency was high for peers (Cronbach’s α = .87), supervisors (Cronbach’s α = .91), and the combined peer-supervisor scale

(Cronbach's α = .89).

### Workload

Workload was assessed using a three-item scale measuring perceived job demands[53]. Items captured the extent to which the volume of work and available resources interfered with respondents' ability to perform their job effectively; however, the study did not include a direct assessment of agency-level caseload requirements or minimum service quotas for peer workers in the survey, interview, or administrative data. Peer specialists responded from a first-person perspective, for example, "The amount of work I have to do interferes with how well it is done", whereas supervisors responded from a third-person perspective reflecting their perceptions of peer staff, for example, "The amount of work expected of them interferes with how well it is done". Responses were recorded on a 5-point Likert-type scale ranging from 1-Strongly Disagree to 5-Strongly Agree, with higher scores indicating greater perceived workload strain. Internal consistency was good for peers (Cronbach's α = .84), supervisors (Cronbach's α = .87), and the combined peer-supervisor scale (Cronbach's α = .86).

### Work-Life Balance

Work–life Balance was assessed using a three-item scale adapted from Hayman (2005)[54]. to capture the extent to which work demands interfered with respondents' personal lives. Items assessed perceived spillover of work into nonwork domains and difficulty managing work and personal responsibilities. Peer specialists responded from a first-person perspective, for example, "My personal life suffers because of my work", whereas supervisors responded from a third-person perspective reflecting their perceptions of peer staff, for example, "Their personal lives suffer because of their work". Responses were recorded on a 5-point Likert-type scale ranging from 1-Strongly Disagree to 5-Strongly Agree, with higher scores indicating greater work–life interference representing poorer work–life balance. Internal consistency was good among peers (Cronbach's α = .88), supervisors (Cronbach's α = .81), and in the combined peer-supervisor scale (Cronbach's α = .87).

### Occupational Self-Efficacy

Occupational Self-Efficacy was assessed using a three-item scale measuring respondents' confidence in their ability to effectively manage job-related demands and challenges. Items assessed perceived competence, problem-solving ability, and preparedness for work demands[55,56]. Peer specialists

responded from a first-person perspective, for example, “I feel prepared to meet most of the demands in my job”, whereas supervisors responded from a third-person perspective regarding peer staff, for example, “They are prepared to meet most of the demands in their job”. Responses were recorded on a 5-point Likert-type scale ranging from 1 -Strongly Disagree to 5 - Strongly Agree, with higher scores indicating greater occupational self-efficacy. Internal consistency was strong among peers (Cronbach’s α = .87), supervisors (Cronbach’s α = .85), and in the combined peer–supervisor scale (Cronbach’s α = .87).

### Lived Experience Climate

Lived Experience Climate was assessed using an eight-item scale measuring perceptions of organizational support, sense of belonging, and respect for individuals with lived experience[57]. Peer specialists and supervisors responded from a first-person perspective, for example, “I am comfortable with how peers are treated by my employer”. The scale included both positively and negatively worded items, with negatively worded items reverse-scored for analysis. Responses were recorded on a 5-point Likert-type scale ranging from 1 - Strongly Disagree to 5 - Strongly Agree, with higher scores reflecting a more positive lived experience climate. Internal consistency was acceptable among peers (Cronbach’s α = .82), supervisors (Cronbach’s α = .88), and in the combined peer–supervisor scale (Cronbach’s α = .83).

### Organizational Climate

Organizational Climate was assessed using a five-item scale measuring perceptions of organizational support for peer specialists, commitment to recovery, and attention to interprofessional dynamics. Peers and supervisors both responded in the first person, reflecting their own perceptions of the organization. The scale was informed by a knowledge-based measure developed by PeerTAC (n.d.)[58] and included five items, such as: “My organization recognizes that peer support specialists are uniquely qualified through their lived experience/expertise of recovery,” and “Our organization addresses the effects of power differentials and related sources of interprofessional tension that can exist between clinical and peer support staff.” Items were rated on a 5-point Likert-type scale ranging from 1 - Strongly Disagree to 5 - Strongly Agree, with higher scores indicating a more supportive organizational climate. Internal consistency was sufficient among peers (Cronbach’s α = .87), supervisors (Cronbach’s α = .79), and in the combined peer-supervisor scale (Cronbach’s α = .86).

### Peer Status and Influence

Peer Status and Influence was assessed using a five-item scale measuring perceptions of peers' authority, influence, and standing within the workplace and was informed by prior work on peer role legitimacy and power dynamics in behavioral health settings[57]. Both peer specialists and supervisors responded to the same items using first-person language, as items reflected perceptions of organizational norms and professional standing that are observable and meaningfully reportable from both roles. Three items were reverse scored to reflect lower perceived status and influence, for example, "Peer staff often end up with very little actual power to influence things". Additional items included: "Peer staff play a unique and important role in substance use services" and "Peer staff are the 'low people on the totem pole'". Items were rated on a 5-point Likert-type scale ranging from 1 - Strongly Disagree to 5 - Strongly Agree, with higher scores indicating greater perceived peer status and influence. Internal consistency was lower than that observed for other study scales, but the construct was retained based on strong theoretical relevance to peer workforce integration (peers: Cronbach's $\alpha = .63$; supervisors: Cronbach's $\alpha = .57$; combined: Cronbach's $\alpha = .61$). Although internal consistency was modest, the scale was retained due to its strong theoretical grounding in peer workforce integration, high face validity, and relevance to power and legitimacy processes that are inherently multifaceted in the peer workforce.

### Supervisor Support

Supervisor Support was assessed using a seven-item scale adapted from mentoring and supervisory support literature in behavioral health and human services settings[57]. The scale captured the extent to which supervisors support peer specialists' professional growth, skill development, and career advancement. Peer specialists responded from a first-person perspective regarding their current or most recent supervisor, for example, "My current/most recent supervisor encourages me to think about career advancement", whereas supervisors responded from a third-person perspective regarding their supervision of peer specialists, for example, "Peer supervisors encourage peer specialists to think about career advancement". Two items were reverse scored to reflect lower perceived supervisory support, for example, "My supervisor has never mentioned career advancement". Items were rated on a 5-point Likert-type scale ranging from 1 - Strongly Disagree to 5 - Strongly Agree, with higher scores indicating greater perceived supervisor support. Internal consistency was high among peers (Cronbach's $\alpha = .91$), supervisors (Cronbach's $\alpha = .87$), and in the combined peer-supervisor scale (Cronbach's $\alpha = .90$).

### Supervisor Working Alliance

Supervisor Working Alliance was assessed using a three-item scale informed by the supervisory working alliance framework and adapted from Efstation, Patton, and Kardash (1990)[59]. The scale captured the quality of the collaborative and relational aspects of supervision including comfort, mutual respect, and openness to peer specialists' perspectives. Peer specialists responded from a first-person perspective regarding their relationship with their supervisor, for example, "I feel comfortable working with my supervisor", whereas supervisors responded from a third-person perspective reflecting their supervisory approach with peer specialists, for example, "Peer specialists are comfortable working with their supervisors". Items were rated on a 5-point Likert-type scale ranging from 1 - Strongly Disagree to 5 - Strongly Agree, with higher scores indicating a stronger supervisory working alliance. Internal consistency was good among peers (Cronbach's $\alpha = .88$), supervisors (Cronbach's $\alpha = .85$), and the combined peer-supervisor scale (Cronbach's $\alpha = .87$).

### Advancement

Advancement was assessed using a four-item scale developed by the evaluation team with input from peer consultants and stakeholder partners to capture perceptions of career progression and professional growth opportunities for peer specialists. Peer specialists responded from a first-person perspective regarding their own advancement opportunities, for example, "I see a pathway for advancement in my role at my organization", while supervisors responded from a third-person perspective regarding the peers they supervise, for example, "I believe there is a clear pathway for advancement for the peers I supervise at my organization". Items assessed organizational support for professional growth, availability of training or tuition assistance, and perceived clarity of advancement pathways. Responses were recorded on a 5-point Likert-type scale ranging from 1 - Strongly Disagree to 5 - Strongly Agree, with higher scores indicating greater perceived advancement opportunities. Internal consistency was good for both peers (Cronbach's $\alpha = .80$), supervisors (Cronbach's $\alpha = .81$), and the peer-supervisor scale (Cronbach's $\alpha = .81$).

### Training

Training was assessed using a four survey items developed by the evaluation team to capture perceptions of the availability, accessibility, and adequacy of training opportunities for peer specialists. Peer specialists responded from a first-person perspective regarding their own training experiences, for example, "I

receive sufficient ongoing training to maintain or improve my skills", while supervisors responded from a third-person perspective regarding the peers they supervise, for example, "Peer specialists receive sufficient ongoing training to maintain or improve their skills". Items assessed access to high-quality, relevant training, ease of accessing training opportunities, and the perceived need for additional training, which was reverse scored for analysis.

Responses were recorded on a 5-point Likert-type scale ranging from 1 - Strongly Disagree to 5 - Strongly Agree, with higher scores indicating more favorable perceptions of training support. Internal consistency was relatively low for peers (Cronbach's $\alpha = .72$), though acceptable for supervisors (Cronbach's $\alpha = .78$) and the combined peer-supervisor scale (Cronbach's $\alpha = .74$). Although internal consistency among peers was modest, the Training scale was retained due to its strong face validity, theoretical relevance to workforce sustainability, and importance as a policy-relevant domain identified by peer consultants and stakeholders during scale development.

### Exemption Process

The Exemption Process scale assessed perceptions of the transparency, fairness, and efficiency of the disqualification exemption process. The scale was developed by the evaluation team with input from peer consultants and key stakeholders to capture system-level experiences relevant to workforce entry and retention. It consisted of three items evaluating whether the exemption process is clearly explained, applied fairly and consistently, and completed in a timely manner. Both peer specialists and supervisors responded in the first person based on their own perceptions of the exemption process. Items were rated on a 5-point Likert-type scale ranging from 1 - Strongly Disagree to 5 - Strongly Agree, with higher scores indicating more favorable perceptions of the exemption process. Internal consistency was excellent for both peers (Cronbach's $\alpha = .90$) and supervisors (Cronbach's $\alpha = .93$), and reliability remained strong when responses were combined across roles (Cronbach's $\alpha = .91$).

### Certification Process

The Certification Training scale assessed perceptions of the Florida CRPS training curricula including its relevance, practical skill development, and coverage of ethics and boundaries. The scale was informed by Tate and colleagues (2022) qualitative interview protocol and consisted of four items evaluating whether the training covered required competencies for supporting

individuals with substance use disorders, reflected the realities of peer work, and provided sufficient practical skills[60]. Both peer specialists and supervisors responded to the items in the first person based on their own experiences with the Florida CRPS training. Because not all supervisors had personally completed the certification process, a “Not Applicable” response option was included for the supervisor block, and analyses were restricted to supervisors who indicated direct experience with CRPS training (N = 39). Items were rated on a 5-point Likert-type scale ranging from 1 - Strongly Disagree to 5 - Strongly Agree, with higher scores indicating more favorable perceptions of the certification training. Internal consistency was excellent for peers (Cronbach’s α = .92) and supervisors (Cronbach’s α = .91), with strong reliability retained when responses were combined across roles (Cronbach’s α = .92).

## *Data Analysis*

Survey responses were exported from Qualtrics on Dec. 9, 2025, and cleaned to ensure accurate coding of missing data and reverse-scored items. Microsoft Excel was used to generate county-level choropleth maps to visualize the geographic distribution of certified peer specialists and survey respondents. SPSS Version 31 was utilized for all statistical analyses.

Multi-item scales were scored by averaging constituent items, with reverse-coded items re-coded prior to scoring. Because the survey utilized role-based branching logic, peers and supervisors responded to parallel items that differed only in perspective, specifically, first-person versus third-person wording. Items that were administered to both peers and supervisors were phrased identically and combined into a single variable for analysis due to survey branch logic. Internal consistency of each scale was assessed using Cronbach’s alpha.

Descriptive statistics were computed to summarize participant demographics, employment characteristics, and survey responses. Normality was assessed through visual inspection of histograms and Q-Q plots, and Levene’s test was used to examine equality of variances. Independent samples t-tests were conducted to examine differences between peer specialists and supervisors, with attention to first-person versus third-person perspectives. Welch’s t-tests were used when the assumption of equal variances was violated. One-way analyses of variance (ANOVA) were conducted to examine differences in key outcomes across employment or organizational characteristics when more than two groups were compared such as perceived differences across employment settings.

Exploratory factor analysis was conducted on items related to burnout, workload, and work-life balance to assess underlying dimensionality and reduce item redundancy prior to inclusion in multivariate models. Factor extraction and retention decisions were guided by eigenvalues, scree plots, and conceptual interpretability. Factor-derived composite scores were then calculated and used in subsequent correlational and regression analyses to improve parsimony and reduce multicollinearity.

For multivariate analyses, Pearson product moment correlations were first examined to identify scale inter-correlations. Multiple linear regression models were then conducted among peer respondents only to examine predictors of two primary outcomes: (1) peer effectiveness and (2) intent to leave. Predictor variables entered into each regression model were selected based on significant bivariate associations and conceptual relevance. Regression assumptions, including linearity, homoscedasticity, independence of errors, and multicollinearity, were evaluated using residual plots, variance inflation factors, and tolerance statistics.

Correlation and regression analyses were restricted to peer respondents because supervisors' responses on most predictor variables reflected their perceptions of peers rather than their own experiences, which could introduce bias or confound associations if included. Limiting the analyses to peer self-reports also ensures that relationships among constructs are based on individuals' direct experiences, providing a more valid assessment of factors influencing workforce outcomes.

Open-ended survey responses were reviewed using a rapid qualitative analytic approach. Members of the research team independently reviewed responses and collectively identified representative and supportive quotations that illustrated key quantitative findings and emergent themes. Selected excerpts were used to contextualize and enrich interpretation of survey results rather than to generate formal qualitative codes or themes. Quotes were edited for clarity without altering their substantive meaning, tone, or context.

## *Sample Characteristics*

### Participant Characteristics

Survey participant characteristics are provided in Appendix 2, Table 6. The average age of peers (*N* = 162) was 44.76 years. Most peers were between 30 and 49 years old at 56.8 percent, with smaller proportions aged 18 to 29 at 10.5 percent and 50 to 69 at 30.2 percent. The majority identified as White at 70.4 percent, followed by Black or African American at 21.0 percent and other races at 8.6 percent. Eighteen percent identified as Hispanic. Most peers were female at 64.8 percent. Educational attainment varied, with 42.6 percent reporting some college and 23.5 percent holding a high school diploma or GED. Smaller proportions held a two-year degree at 13.6 percent, a four-year degree at 14.8 percent, or a graduate or professional degree at 5.5 percent.

Supervisors (*N* = 53) were similarly concentrated in the 30 to 49 age range at 69.8 percent, with an average age of 41.91 years. Most supervisors identified as White at 81.1 percent, followed by other races at 11.3 percent and Black or African American at 7.5 percent. A total of 20.8 percent identified as Hispanic. The majority were female at 69.8 percent. Supervisors reported higher levels of educational attainment than peers: 35.8 percent held a master's degree, 15.1 percent held a four-year degree, and 15.1 percent held a two-year degree. Smaller proportions held a high school diploma or GED at 11.3 percent or a doctorate or professional degree at 5.7 percent.

### Employment Characteristics

Survey participants' employment characteristics are presented in Appendix 2, Table 7. Most peer specialists were employed full-time at 83.3 percent, with smaller proportions working part-time at 13.0 percent, on a contract or per diem basis at 1.2 percent, or in volunteer roles at 1.9 percent. All peers, 100 percent, held CRPS or CRPS-P certification. Specific endorsements included CRPS-Adult at 88.3 percent, CRPS-Family at 16.7 percent, CRPS-Youth at 6.8 percent, CRPS-Veteran at 6.2 percent, and CRPS-Criminal Justice at 5.6 percent. Peer salaries were most commonly in the $30,000 to $49,000 range at 55.6 percent, with 20.9 percent earning less than $30,000 and 20.3 percent earning more than $50,000.

Among supervisors, 96.2 percent were employed full-time. Just over half, 52.8 percent, held CRPS or CRPS-P certification, while 47.2 percent were not certified. Among certified supervisors, 96.4 percent held a CRPS-Adult endorsement, followed by CRPS-Family at 32.1 percent, CRPS-Youth at 14.3 percent, CRPS-Veteran at 10.7 percent, and CRPS-Criminal Justice at 3.6 percent. Supervisor salaries were higher overall, with 34.0 percent earning $70,000 or more, 20.8 percent earning $40,000 to $49,000, 20.8

percent earning $50,000 to $59,000, and 17.0 percent earning $60,000 to $69,000.

### Workplace Characteristics

Workplace characteristics of peer specialists and their supervisors are presented in Appendix 2, Table 8. Among peers, just over half, 50.6 percent, were employed by community-based providers or nonprofit organizations, while 23.5 percent worked in peer-run or consumer-run organizations. Smaller proportions were employed in hospitals or emergency departments at 8.6 percent, state or county facilities at 4.9 percent, veteran services at 1.2 percent, family-run organizations at 1.2 percent, universities at 0.6 percent, or other self-reported settings at 6.2 percent, including healthcare systems, insurance providers, homeless shelters, recovery community organizations, problem-solving courts, residential programs, and sheriff's office or community outreach programs.

Supervisors were similarly concentrated in community-based and peer-run organizations, with 28, representing 52.8 percent, employed in community-based settings and 16, representing 30.2 percent, in peer-run settings. Of these, 10 of the 28 community-based supervisors, 35.7 percent, and 14 of the 16 peer-run supervisors, 87.5 percent, held CRPS or CRPS-P credentials.

Peers reported serving diverse populations in addition to individuals with substance use disorders, most commonly individuals with mental health needs at 81.5 percent, those experiencing homelessness at 77.2 percent, individuals with trauma histories at 56.2 percent, justice-involved individuals at 55.6 percent, and individuals with serious mental illness at 43.8 percent. Smaller proportions reported serving survivors of trafficking at 27.2 percent, transition-age youth at 22.2 percent, individuals experiencing early psychosis at 22.2 percent, racial and ethnic minority populations at 35.2 percent, and other populations at 4.9 percent.

Supervisor respondents reflected similar trends, with high representation in mental health at 90.6 percent, homelessness at 90.6 percent, trauma at 88.7 percent, justice-involved populations at 73.6 percent, and serious mental illness at 52.8 percent.

Most peers were based in urban counties at 56.8 percent, followed by suburban counties at 31.5 percent and rural areas at 11.7 percent. Supervisors were more evenly distributed across urban counties at 45.3 percent and suburban counties at 41.5 percent, with lower representation in rural counties at 13.2 percent. See Figures 2 and 3.

**Figure 2. Distribution of Peer Survey Respondents by Primary Work County**

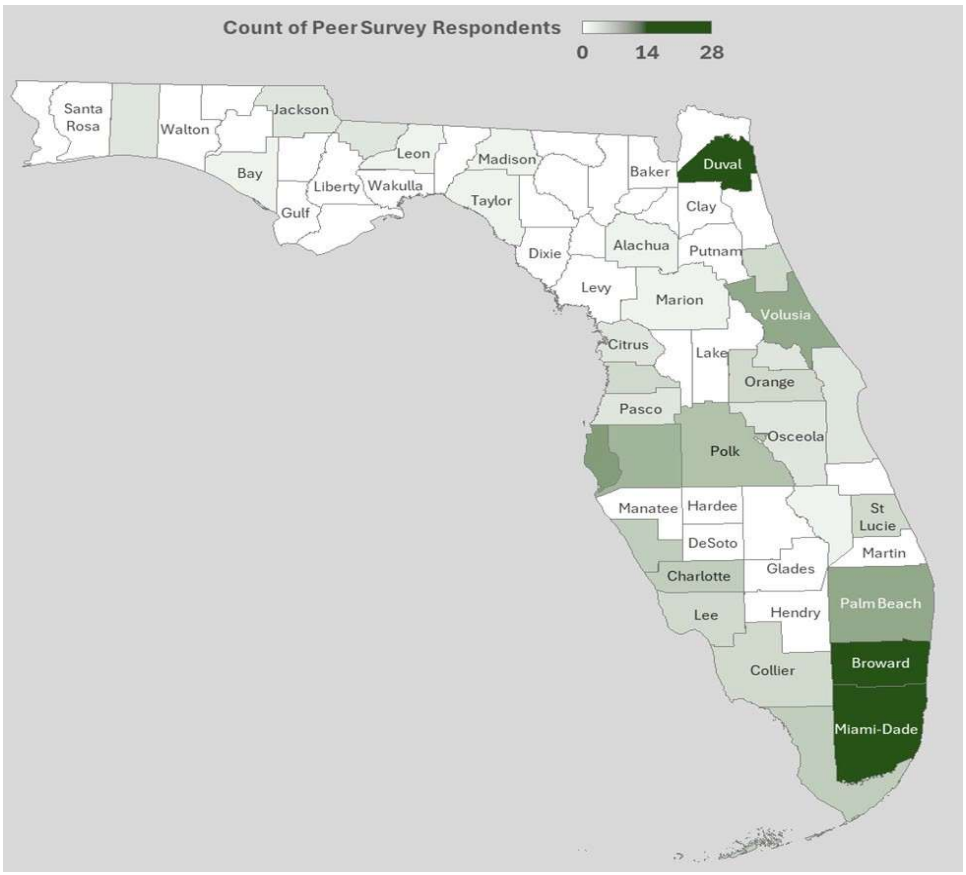
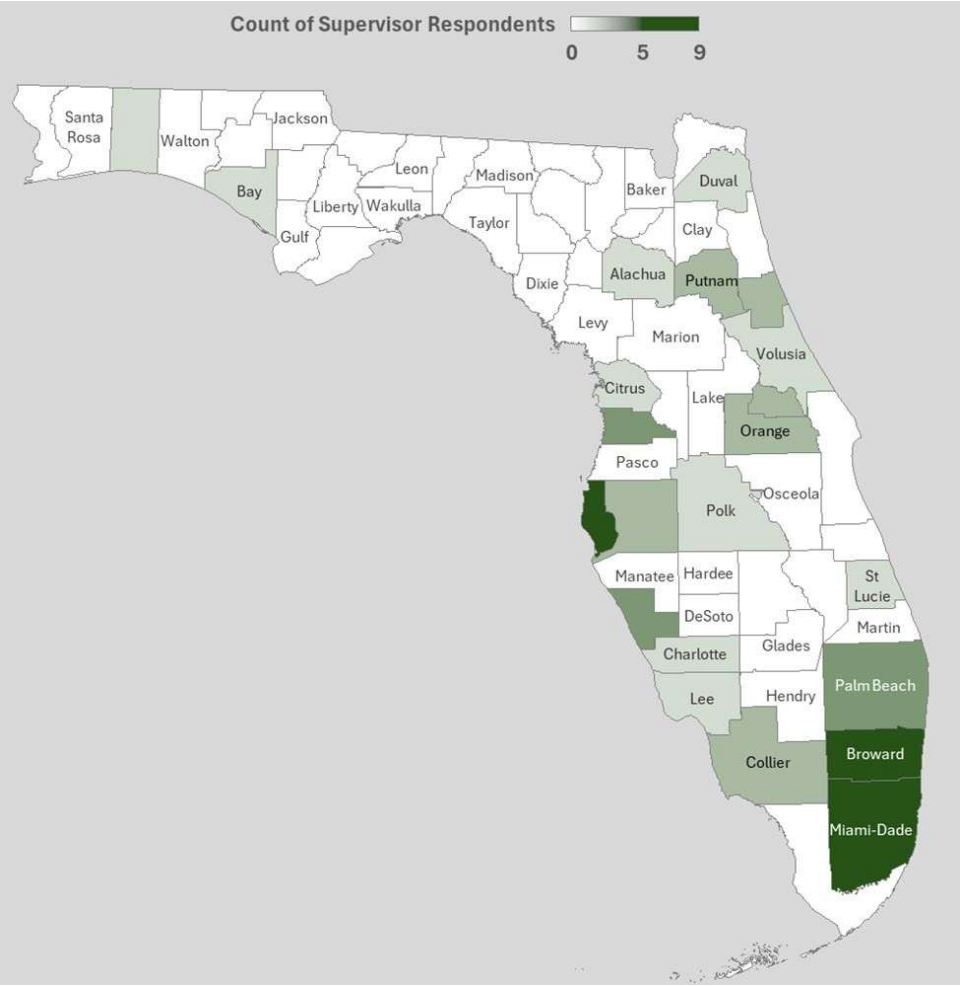


**Figure 3. Distribution of Supervisor Survey Respondents by Primary Work County**




## Qualitative Interviews

This study used qualitative methods to explore the experiences and challenges of certified peer specialists, peer support supervisors, and those in peer administrative roles in the state of Florida. A qualitative inquiry sought to gain insight into experiences of peer workforce development, role functioning, integration, and system-level barriers. Recruitment was conducted concurrently using the same procedures previously described for the mixed-methods survey. Semi-structured interviews were conducted with recovery peer specialists, peer supervisors, and administrators working in DCF-funded behavioral health programs across Florida. Questions were asked about their overall experiences of professional identity, workforce integration, supervision, training and certification processes, compensation, sustainability and advancement, and systemic or policy barriers.

Other information such as demographic characteristics, work setting, years of experience, certification status, and geographic region was also gathered during the interviews. Questions were open-ended and included probing and follow-up questions. Interview protocol was approved through the USF Institutional Review Board (IRB# 009100). Recruitment targeted certified recovery peer specialists, peer supervisors, and peer administrators, such as a non-peer executive employees, employed in DCF-funded behavioral health programs in Florida.

Participants were recruited by email outreach to program directors and supervisors, statewide behavioral health workforce networks, and recovery community organizations. Participants were eligible for the study if they met the following inclusion criteria: currently employed in a peer support role (peer specialist, supervisor, or administrator) and working within DCF-funded programs in Florida.

Seventy-six participants were interviewed. A total of 64 were analyzed after removing participants who did not work with an SUD population ($n$ = 1) or within a DCF-funded program ($n$ = 11). Sample size was guided by the number of interviews needed to achieve saturation of data, and research suggests a qualitative sample size of 20 to 30 or until saturation is reached[61]. Participants were interviewed by the research team from November to December 2025. Participants were provided with an explanation of the research study, their rights as a research participant, informed consent, and confidentiality of all collected data. Interviews were conducted over Teams and audio-recorded and transcribed in Teams. Interviews were conducted using semi structured interview protocols, with each group (peer, supervisor, administrator) having an individualized protocol. Interviews lasted approximately 45 minutes each ($M$ = 44.8 minutes, $SD$ = 9.5). Participants were compensated with $40 Amazon gift cards. All interviews were audio-recorded, transcribed verbatim in the Teams platform, and de-identified for analysis.

## *Data Analysis*

This study employed a narrative summarization approach to analyze qualitative interview data[62]. Narrative summarization offers a systematic method for synthesizing qualitative data while preserving the integrity and richness of participants' stories[63,64]. This approach emphasizes understanding experiences as coherent wholes rather than fragmenting them into discrete themes, allowing for a more holistic understanding of participants' experiences in the peer workforce[65]. The analysis followed a four-step process to systematically synthesize individual narratives into a comprehensive understanding of the peer workforce experience.

### Step 1

Initial Data Familiarization. The research team began by reading through all interview transcripts without taking notes to achieve immersion in the material and gain a holistic sense of participants' experiences[64]. Each data source was assigned an identifier such as a pseudonym or case number and logged into a systematic tracking sheet to maintain participant confidentiality while enabling cross-case analysis[65].

### Step 2

Individual Case Summaries. After familiarization, transcripts were re-read systematically[66]. For each participant, the team developed one to two page narrative summaries capturing: (a) the participant's overall story arc or main message[63]; (b) critical incidents or turning points in their peer support journey[64]; (c) their perspective on workforce challenges and opportunities; and (d) contextual factors shaping their experience, including organizational and systemic influences[67]. Two to three exemplar quotes were selected to preserve each participant's voice[62]. Analytical notes were added to document interpretations, theoretical connections, and questions raised by each case[68]. As summaries progressed, the team began noting similarities and differences across cases[69].

### Step 3

Cross-Case Analysis. Following completion of all individual summaries, the team conducted cross-case analysis[70]. All summaries were read sequentially to identify: (a) recurring storylines or narrative patterns across participants[63]; (b) divergent cases or outlier narratives that challenged dominant patterns[64]; (c) common temporal sequences in career trajectories and workforce experiences[65]; and (d) shared meaning-making patterns regarding peer support identity and role[67]. Analytical memos were written to document emerging patterns, organized by narrative types such as, "transformation stories," or "stuck stories", thematic clusters, and temporal patterns[71].

### Step 4

Integration and Write-Up. The final step involved developing a narrative framework showing how individual stories related to each other within the broader context of Florida's peer workforce[65,70]. Representative case examples were selected for each identified pattern to illustrate key findings[62]. The findings were written as a coherent meta-narrative that wove together individual stories while preserving their uniqueness through direct quotes and case examples[68,63].The team returned to original transcripts to verify interpretations and extract additional supporting quotes[72]. This iterative process ensured that the final narrative accurately represented participants' experiences while

providing actionable insights for workforce development.

## *Sample Characteristics*

The final sample included peer specialists (*n* = 42), peer supervisors (*n* = 19), and administrators (*n* = 3). Among peer specialists, 56 were certified, 4 were in process of certification, and 1 was not yet certified. Participants represented diverse geographic regions and organizational settings, including RCOs, peer-led facilities, hospitals, and integrated behavioral health programs.

The sample was predominantly female (75.0 percent), with a mean age of 44.8 years (*SD* = 12.5, range 22-72). The racial composition was primarily White (84.4 percent), followed by Black/African American (9.4 percent) and Mixed Race (4.7 percent). Regarding ethnicity, 76.6 percent identified as Non-Hispanic/Latino and 21.9 percent as Hispanic/Latino. Educational backgrounds varied widely, with 26.6 percent reporting some college education, 21.9 percent holding bachelor's degrees, 17.2 percent having associate degrees, and 12.5 percent holding master's degrees. The majority of participants worked in urban settings (90.6 percent) across 33 Florida counties/regions, with the highest representation from Sarasota-Manatee (12.5 percent), Broward (10.9 percent), and Volusia (7.8 percent). Participants reported substantial experience in peer-related roles, with a mean of 5.0 years (*SD* = 5.4, range 0.1-28 years). See Appendix 2 Table 9 for qualitative interview sample characteristics.

Interview durations averaged 44.8 minutes (*SD* = 9.5), indicating substantive engagement with the research questions.

# RESULTS

Results from this comprehensive, multi-method evaluation are presented below and organized by study objective.

## Objective 1. Effectiveness of Peer Specialists

The effectiveness of recovery peer specialists in supporting Floridians with opioid-related and other substance use disorders across ROSCs was examined through an analysis of FASAMS data and survey responses from recovery peer specialists and peer supervisors.

### *Secondary Data Analysis*

FASAMS data were used to examine whether documented involvement of a CRPS was associated with clinical treatment engagement and successful discharge from clinical treatment services. Clinical treatment engagement and discharge outcomes were examined separately. Analyses of clinical treatment engagement were conducted using clinical service records and were not anchored to discharge dates. Discharge-related outcomes were examined independently using completed treatment episode data with complete discharge dates and reasons for discharge.

#### *Is CRPS involvement associated with a higher likelihood of receiving Medication Assisted Treatment (MAT)?*

Among CRPS-involved service recipients, 2,493 (12.1 percent) were enrolled in MAT at the time of the first documented service event compared to 2,793 (8.7 percent) among the non-CRPS recipients. This difference between groups was statistically significant ($\chi^2(1) = 166.97$, $p < .001$) indicating CRPS-involved service recipients were significantly more likely to be enrolled in MAT compared to non-CRPS-involved recipients. The magnitude of association, however, was small ($\varphi = .06$). Service recipients with CRPS involvement were only slightly more likely to be enrolled in MAT at their first clinical treatment service compared to those without CRPS involvement.

A binary logistic regression analysis showed CRPS involvement was a statistically significant predictor of MAT enrollment (Odds Ratio = 1.46, $p < .001$). Service recipients who received peer services had 46 percent greater likelihood of being enrolled in MAT compared to individuals who did not have CRPS involvement. After adjustment for recipient race, sex, and ethnicity, CRPS involvement remained a significant predictor of MAT enrollment (Odds Ratio = 1.42, $p < 001$), indicating that even after adjusting for recipient demographic factors, CRPS involved recipients remained 42 percent more

likely than non-CRPS recipients to be enrolled in MAT at the time of the first documented service event.

### *Is CRPS involvement associated with greater intensity and longer duration of participation among adult service recipients?*

Among service recipients with CRPS involvement, the median number of clinical treatment services received was two (IQR = 5), with a mean of 9.88 (*SD* = 26.89). Among service recipients without CRPS involvement, the median number of clinical treatment services received was five (IQR = 17), with a mean of 33.27 (*SD* = 92.58). In both groups, the distribution of clinical treatment service utilization was highly positively skewed, suggesting that most service recipients received relatively few clinical treatment services, while a smaller subset received substantially higher volumes of services.

Service recipients without CRPS involvement received a higher volume of clinical treatment services during the study period compared to service recipients with CRPS involvement. This difference was statistically significant ($U$ = 237,061,134.50, $Z$ = −55.20, $p < .001$), indicating greater clinical treatment service utilization among non-CRPS service recipients. The effect size was small-to-moderate ($r$ = .24), reflecting a meaningful but not substantial difference in clinical treatment intensity between groups.

Among service recipients with CRPS involvement ($n$ = 20,521), the median number of months engaged in clinical treatment services was one month (IQR = 1.0). The mean duration was 1.90 months (*SD* = 1.21), with a maximum of 11 months. The distribution was positively skewed, indicating that most CRPS-involved service recipients received clinical services in a limited number of months during the study period. Among service recipients without CRPS involvement ($n$ = 32,175), the median duration of clinical treatment engagement was three months (IQR = 5.0). The mean duration was 5.30 months (*SD* = 6.93), with a maximum of 36 months. Similar to the CRPS group, the distribution was positively skewed, with a subset of service recipients engaged across multiple months.

A Mann-Whitney U test showed a statistically significant difference in duration of clinical engagement between groups ($U$ = 210,267,331, $Z$ = −72.88, $p < .001$), such that service recipients without CRPS involvement had a significantly higher number of months of clinical treatment engagement. The effect size was moderate ($r$ = .32), suggesting a meaningful difference in clinical service duration of engagement between groups.

Findings of both service intensity and duration were contrary to expected, though caution is urged in drawing conclusions of ineffectiveness. It is possible that CRPS

engagement may contribute to a more rapid treatment response, potentially reducing the necessary duration and intensity of services. The lack of clinical-level data prevents direct evaluation of this possibility. Additionally, follow-up analyses should examine a dose response of CRPS visits as multiple may be required to have an effect on clinical service treatment engagement.

It is also possible that these findings are an artifact of the available data configuration and associated analyses. For instance, it was difficult to establish temporal order and to capture the dynamics of movement across level of care and settings. Further, clinical treatment services were examined in the aggregate and specific types of services that may be most relevant could not be analyzed in both the CRPS and comparison dataset with the data available at the time of this analysis. The aggregate service count may include treatment services that may or may not yield a recommendation for follow-up, like a clinical assessment or for which follow-up may be intermittent or as needed such as case management. Evaluating complete episodes of clinical treatment may provide a more appropriate and meaningful examination of effectiveness than relying solely on service counts or duration. This is examined below.

### *Is CRPS involvement associated with a higher likelihood of successfully completing a treatment episode of care?*

A total of 102,414 treatment episodes were analyzed to examine whether CRPS involvement was associated with successful discharge from treatment. Of the 88,675 episodes that did not include peer services, 37,247 were successfully discharged, resulting in a completion rate of 42.0 percent. In comparison, among the 13,739 episodes with CRPS involvement, 7,027 were successfully discharged, with a completion rate of 51.0 percent. This difference was statistically significant, $\chi^2(1) = 394.29$, $p < .001$. In a bivariate logistic regression model comparing CRPS involvement with successful discharge, episodes with CRPS involvement had 44 percent greater likelihood of successful discharge from treatment services compared to episodes without CRPS involvement (Odds Ratio = 1.44, 95 percent CI [1.39, 1.49], $p < .001$).

A multivariable logistic regression analysis was further conducted to examine whether CRPS involvement was associated with successful discharge when adjusting for age, race, ethnicity, gender, treatment locale, and the sum of services received. After adjustment, episodes with CRPS involvement still showed significantly greater likelihood of successful discharge compared to episodes without CRPS involvement (Odds Ratio= 1.66, 95 percent CI [1.60,1.72], $p < .001$). This indicated that CRPS-involved episodes had approximately 66 percent higher likelihood of successful discharge from treatment services, even when controlling demographic characteristics and treatment settings.

Other than CRPS involvement, older age was associated with a small increase in likelihood of successful discharge (Odds Ratio = 1.01 per year, p < .001). Female service recipients had slightly lower likelihood of successful completion compared to male service recipients (Odds Ratio = 0.96, p = .001). Service recipients who were Hispanic were associated with slightly higher likelihood of successful discharge relative to non-Hispanic service recipients (Odds Ratio = 1.04, p = .018). Treatment setting was significantly associated with successful discharge (overall p < .001), with substantially higher likelihood observed in residential (Odds Ratio = 2.27), justice (Odds Ratio = 2.12), and acute settings (Odds Ratio = 1.89), compared to treatment services received in provider premises.

Taken together, the association between CRPS involvement and successful discharge from treatment services remained robust after adjusting for demographic characteristics, treatment setting, and service intensity.

## *Mixed-Method Survey*

### Effectiveness

Effectiveness was measured using a composite scale, ranging from 1 (strongly disagree) to 5 (strongly agree), that examined perceptions of peers' impact in their roles. Mean composite scores on a measure of perceived effectiveness were high amongst peers (*M* = 4.66) and peer supervisors (*M* = 4.82). An examination of peers' individual item responses on a 5-point scale suggests a strong belief that their peer role provides unique supports (*M* = 4.60) and contributes to positive outcomes (*M* = 4.77). Peer supervisors overwhelmingly endorse the belief that peers provide unique support that complements clinical services (*M* = 4.79) and contributes to positive outcomes that would not have occurred otherwise (*M* = 4.87). Peer supervisors report high confidence in peers' abilities to make a positive impact (*M* = 4.81).

> *"I really believe that peer support works. I've had several participants who shared with me that it's so much better to talk with someone who has been through your struggle and who gets it. The conversations are more effective. I've seen a lot of success stories through our organization."* [Peer Open-Ended Response]

An independent samples *t* test indicated that supervisors rated peer specialists' effectiveness significantly higher than peers rated themselves, *t*(143.34) - 2.03, *p* =.044, although mean ratings were high among both groups.

Additional analyses examined whether peers' perceptions of effectiveness differed based on supervisors' peer status. Specifically, perceptions of peer effectiveness were

compared between peer specialists who reported having a supervisor with lived experience as a peer and those whose supervisor did not have peer experience. This comparison did not reveal statistically significant differences in perceived peer effectiveness, $t(156.47) = 1.74$, $p = .085$.

Table 2 presents the correlation matrix for peer effectiveness and related protective and resource-based factors. Perceived effectiveness demonstrated significant positive associations with several protective and resource-based factors. Specifically, perceived effectiveness was positively correlated with role clarity ($r = .63$, $p < .01$), occupational self-efficacy ($r = .63$, $p < .01$), and recovery capital ($r = .59$, $p < .01$). Additional significant positive associations were observed with organizational climate ($r = .48$, $p < .01$), lived experience climate ($r = .36$, $p < .01$), supervisor working alliance ($r = .49$, $p < .01$), advancement opportunities ($r = .44$, $p < .01$), training ($r = .39$, $p < .01$), and certification ($r = .50$, $p < .01$). Smaller but significant positive correlations were also present for peer status and influence ($r = .20$, $p < .05$), supervisor support ($r = .30$, $p < .01$), and exemption process ($r = .19$, $p < .05$). Perceived effectiveness was not significantly associated with burnout ($r = -0.15$, *ns*), which may indicate that peers' perceptions of their effectiveness are more strongly linked to clarity of role, professional skills, and organizational supports than to experienced job strain.

**Table 2. Correlation Matrix**

| Scale | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Intent to Leave (1) | | | | | | | | | | | | | | |
| Effectiveness (2) | -.31** | | | | | | | | | | | | | |
| Role Clarity (3) | -.37** | .63** | | | | | | | | | | | | |
| Burnout (4) | .53** | -0.15 | -.27** | | | | | | | | | | | |
| Occupational Self-Efficacy (5) | -.35** | .63** | .63** | -.23** | | | | | | | | | | |
| Lived Experience Climate (6) | -.41** | .36** | .49** | -.41** | .40** | | | | | | | | | |
| Organizational Climate (7) | -.38** | .48** | .49** | -.35** | .49** | .70** | | | | | | | | |
| Status and Influence (8) | -.32** | .20** | .26** | -.35** | .23** | .64** | .52** | | | | | | | |
| Supervisor Support (9) | -.46** | .30** | .38** | -.40** | .40** | .56** | .68** | .52** | | | | | | |
| Working Alliance (10) | -.40** | .49** | .50** | -.31** | .50** | .54** | .64** | .37** | .65** | | | | | |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Advancement (11) | -.49** | .44** | .42** | -.39** | .43** | .53** | .67** | .42** | .71** | .58** | | | | |
| Training (12) | -.43** | .39** | .52** | -.33** | .43** | .52** | .51** | .46** | .58** | .52** | .50** | | | |
| Exemption (13) | -.17* | .19* | .29** | -0.08 | 0.13 | .16* | .22** | 0.13 | .20* | .17* | .29** | .26** | | |
| Certification (14) | -.19* | .50** | .38** | -0.10 | .40** | .33** | .49** | .16* | .37** | .45** | .48** | .43** | .37** | |
| Recovery Capital (15) | -.32** | .59** | .59** | -.22** | .60** | .35** | .41** | .17* | .32** | .47** | .43** | .38** | 0.15 | .40** |

*Note.* Only peer responses were included in the correlation matrix. *Correlation is significant at the 0.05 level (2-tailed), meaning there is a less than 5 percent probability that the observed correlation occurred by chance.

**Correlation is significant at the 0.01 level (2-tailed), meaning there is a less than 1 percent probability that the observed correlation occurred by chance. Non-significant correlations (no asterisk) may reflect weaker or no meaningful relationship between the variables. The “Burnout” scale represents a composite of the burnout, workload, and work–life balance subscales, as determined by factor analysis.

*Source*: Mixed-Methods Survey

A multiple regression analysis was conducted to examine factors associated with peer specialists’ perceptions of their own effectiveness (see Table 3). The analysis included peers only ($N$ = 162) and incorporated variables that were significantly correlated with peer effectiveness in correlational analyses. The overall model was statistically significant, $F(12,149) = 17.04$, $p < .001$, and accounted for approximately 55 percent of the variance in peer effectiveness ratings (adjusted $R^2 = 0.545$).

The results indicate that peers who reported greater clarity in their job responsibilities rated themselves as more effective ($B = 0.248$, $p < .001$). In addition, peers with higher occupational self-efficacy perceived higher effectiveness ($B = 0.224$, $p = .002$). Satisfaction with the Florida CRPS certification process was positively associated with perceived effectiveness ($B = 0.155$, $p = .004$). Unexpectedly, greater perceived support from supervisors was associated with slightly lower self-rated effectiveness ($B = -0.134$, $p = .027$), which may suggest that additional support may not directly translate to enhanced perceptions of role effectiveness for peers. Other factors, including lived experience climate, organizational climate, status and influence, working alliance, advancement opportunities, training, exemption status, and recovery capital, did not uniquely predict perceptions of effectiveness, though recovery capital demonstrated a marginal positive association with effectiveness ($p$ =.06).

**Table 3. Peer Effectiveness Regression Analysis**

| | | | | 95 percent CI | | |
|---|---|---|---|---|---|---|
| **Variable** | **B** | ***SE*** | ***t*** | ***LL*** | ***UL*** | ***p*** |
| Constant | 1.085 | 0.298 | 3.641 | 0.496 | 1.673 | <.001 |
| Role Clarity | 0.248 | 0.07 | 3.565 | 0.111 | 0.385 | <.001 |
| Occupational Self-Efficacy | 0.224 | 0.07 | 3.201 | 0.086 | 0.362 | 0.002 |
| Lived Experience Climate | -0.078 | 0.075 | -1.045 | -0.225 | 0.069 | 0.298 |
| Organizational Climate | 0.082 | 0.073 | 1.124 | -0.062 | 0.227 | 0.263 |
| Peer Status and Influence | 0.041 | 0.064 | 0.642 | -0.085 | 0.167 | 0.522 |
| Supervisor Support | -0.134 | 0.06 | -2.233 | -0.253 | -0.015 | 0.027 |
| Supervisor Working Alliance | 0.084 | 0.06 | 1.395 | -0.035 | 0.204 | 0.165 |
| Advancement | 0.079 | 0.058 | 1.356 | -0.036 | 0.194 | 0.177 |
| Training | -0.014 | 0.062 | -0.227 | -0.136 | 0.108 | 0.821 |
| Exemption | -0.027 | 0.035 | -0.785 | -0.097 | 0.042 | 0.434 |
| Certification | 0.155 | 0.053 | 2.889 | 0.049 | 0.26 | 0.004 |
| Recovery Capital | 0.14 | 0.074 | 1.9 | -0.006 | 0.285 | 0.059 |

*Note*. B = unstandardized beta; SE = standard error CI = confidence interval; *LL* = lower limit; *UL* = upper limit. P-values indicate the probability that the observed relationship occurred by chance if there were truly no effect. Values below .05 are generally considered statistically significant, meaning there is less than a 5 percent likelihood that the result is due to random variation. The composite burnout, workload, and work-life balance subscale was not correlated with perceptions of peer effectiveness and was excluded from the model.
*Source*: Mixed-Methods Survey

***Work Setting.*** Appendix 2 Table 10 presents peer perspectives of their own effectiveness across work settings. Workplace settings were grouped into three categories for analysis. Peer-led or consumer-led organizations including peer-run, consumer-run, and family-run organizations. Community-based nonprofit or mixed-model providers including community-based nonprofits, non-peer agencies that operate some peer-led services, universities, and Veteran's Affairs programs delivered in community settings. Institutional or public sector settings including state, county, or city facilities, hospitals or emergency departments, Veteran's Affairs programs delivered in institutional settings, and other institutional workplaces. A one-way ANOVA indicated that perceived effectiveness did not differ significantly by primary work setting, $F(2, 159) = 0.76$, $p = .471$. Post hoc Bonferroni comparisons also revealed no significant pairwise differences between settings (all $p \geq .754$). Although peers in institutional or public sector settings had slightly higher average ratings, these differences were not statistically significant, which indicates that peers' perceived effectiveness is consistently high regardless of organizational context.

> *"It is a pleasure to have a peer recovery specialist in the hospital setting. They are able to connect with patients in ways that medical professionals can't and*

*help plant the seed to change."* [Supervisor Open-Ended Response]

***County Type.*** Appendix 2 Table 11 presents perceived peer effectiveness by the type of county peers primarily work in, either urban, suburban, or rural. A one-way ANOVA indicated that perceived effectiveness did not differ significantly across county types, $F(2, 159) = 0.87$, $p = .419$. Post-hoc Bonferroni comparisons also showed no significant pairwise differences between county types (all $p \geq .674$). Peer specialists reported high perceived effectiveness regardless of whether they worked in urban, suburban, or rural counties. Differences in mean scores were minimal and not statistically significant, suggesting that county type alone does not meaningfully influence peers' perceptions of their effectiveness.

***Supervisor Type.*** Appendix 2 Table 12 presents perceived peer effectiveness by supervisor type. An independent samples *t*-test indicated that peers supervised by non-peer supervisors reported slightly higher perceived effectiveness ($M = 4.76$, $SD = 0.46$) than those supervised by peer supervisors ($M = 4.59$, SD = 0.81); however, this difference did not reach statistical significance, $t(156.47) = 1.74$, $p = .085$. Although the difference was modest and should be interpreted cautiously, the pattern suggests that peers supervised by non-peers may report marginally higher perceived effectiveness.

## Objective 2: Barriers to Integrating and Retaining Peer Specialists

## Objective 2a. An Exploration of Specific Barriers

### *Mixed Method Survey*

#### Intent to Leave

Intent to leave, a proxy for turnover risk, was measured using a three-item composite assessing peers' and supervisors' likelihood of leaving their positions, rated from 1 (extremely unlikely) to 5 (extremely likely). Overall, mean scores were low, indicating that both peers ($M = 1.86$) and supervisors ($M = 1.66$) generally reported low intentions to leave their roles.

#### Barriers to Integration and Retention

Table 4 presents a comparison of peers' and supervisors' responses across key workplace and workforce-related measures relevant to integration and retention, including intent to leave, role clarity, burnout, workload, work-life balance, supervision, professional development, and other organizational factors.

Intent to leave did not differ significantly between groups ($M = 1.66$ for supervisors, $M =$

1.86 for peers; $p$ = .203). Although intent to leave was similar across groups, several differences emerged across workplace-related factors. Compared with supervisors, peer specialists reported higher role clarity ($M$ = 4.43 vs. 3.86; $p$ < .001), occupational self-efficacy ($M$ = 4.41 vs. 4.07; $p$ = .003), supervisor support ($M$ = 4.27 vs. 3.84; $p$ = .002), and perceived opportunities for advancement ($M$ = 4.28 vs. 3.92; $p$ = .01). Conversely, peers reported lower burnout ($M$ = 2.56 vs. 3.19; $p$ < .001), workload ($M$ = 1.99 vs. 2.60; $p$ <.001), and work–life balance concerns ($M$ = 1.87 vs. 2.55; $p$ < .001) than peers, suggesting that supervisors may perceive higher job demands or stress levels.

Differences were also observed in training and exemption processes, with peers reporting greater satisfaction with training (M = 3.86 vs. 3.33; $p$ < .001) and a more favorable view of the exemption process (M = 3.02 vs. 2.60; $p$ = .028). No significant differences were found for lived experience climate, organizational climate, peer status and influence, supervisor working alliance, or certification process.

**Table 4. Barriers to Integration and Retention by Role**

| | Item Direction | Peers (N=162) | Supervisors (N=53) | Difference | P Value |
|---|---|---|---|---|---|
| Intent to Leave* | ↓ | 1.86 | 1.66 | -0.20 | 0.203 |
| Perceived Effectiveness | ↑ | 4.66 | 4.82 | 0.16 | 0.044 |
| Recovery Capital | ↑ | 4.43 | - | - | - |
| Role Clarity | ↑ | 4.43 | 3.86 | -0.57 | <.001 |
| Burnout | ↓ | 2.56 | 3.19 | 0.63 | <.001 |
| Workload | ↓ | 1.99 | 2.60 | 0.61 | <.001 |
| Work-life Balance | ↓ | 1.87 | 2.55 | 0.68 | <.001 |
| Occupational Self-Efficacy | ↑ | 4.41 | 4.07 | -0.34 | 0.003 |
| Lived Experience Climate* | ↑ | 4.05 | 4.04 | -0.01 | 0.899 |
| Organizational Climate* | ↑ | 4.20 | 4.37 | 0.17 | 0.117 |
| Peer Status and Influence* | ↑ | 3.86 | 4.02 | 0.16 | 0.189 |
| Supervisor Support | ↑ | 3.84 | 4.27 | 0.43 | 0.002 |
| Supervisor Working Alliance | ↑ | 4.31 | 4.41 | 0.10 | 0.407 |
| Advancement | ↑ | 3.92 | 4.28 | 0.36 | 0.01 |
| Training | ↑ | 3.86 | 3.33 | -0.53 | <.001 |
| Exemption Process* | ↑ | 3.02 | 2.60 | -0.42 | 0.028 |
| Certification Process* | ↑ | 4.28 | 4.11 | -0.17 | 0.295 |

*Note.* Mean differences are reported as the supervisor mean minus the peer mean, such that positive values indicate higher scores among supervisors, specifically, mean difference = $M_{Supervisor} - M_{Peer}$). Directionality indicates whether higher scores reflect a favorable outcome (↑) or less favorable outcome (↓). Intent to leave was measured using three items scored on a 1–5 scale ranging from 1 (Extremely Unlikely) to 5 (Extremely Likely). Recovery Capital was measured for peers only. Supervisor sample size for the Certification Process scale was n = 43, as supervisors could select "N/A" on this item. Scales marked with an asterisk (*) used identical item wording for peers and supervisors.

P values indicate the probability that the observed difference could have occurred by chance if there were truly no difference between peers and supervisors. Values less than .05 are generally considered statistically significant, meaning

the likelihood that the observed difference is due to chance is less than 5 percent.
*Source*: Mixed-Methods Survey

Table 5 presents differences in workplace experiences and perceptions between peers supervised by another peer versus peers supervised by a non-peer. Overall, peers with non-peer supervisors reported a slightly higher intent to leave compared with peers with peer supervisors ($M$ = 2.06 vs. 1.73; $p$ = .033), although perceived effectiveness and recovery capital did not differ significantly between the groups.

Significant differences emerged across several workplace characteristics. Peers with peer supervisors reported more favorable perceptions of the lived experience climate ($M$ = 4.17 vs. 3.88; $p$ = .021), organizational climate ($M$ = 4.35 vs. 3.97; $p$ = .007), peer status and influence ($M$ = 4.05 vs. 3.58; $p$ < .001), supervisor support ($M$ = 4.04 vs. 3.55; $p$ = .004), advancement opportunities ($M$ = 4.07 vs. 3.70; $p$ = .023), and training ($M$ = 4.02 vs. 3.62; $p$ = .003). Other measures, including role clarity, burnout, workload, work–life balance, occupational self-efficacy, exemption and certification processes, and supervisor working alliance, did not differ significantly between groups.

> *"...Peers should be supervised by a peer specialist and by someone who truly understands the role of a peer."* [Peer Open-Ended Response]

**Table 5. Peer Supervisor vs. Non-peer Supervisor Comparison (Peer Respondents Only)**

| | Peer Supervisor (N=97) | Non-peer Supervisor (N=65) | Difference | P Value |
|---|---|---|---|---|
| Intent to Leave | 1.73 | 2.06 | 0.33 | 0.033 |
| Perceived Effectiveness | 4.59 | 4.76 | 0.17 | 0.085 |
| Recovery Capital | 4.42 | 4.45 | 0.03 | 0.807 |
| Role Clarity | 4.44 | 4.42 | -0.02 | 0.862 |
| Burnout | 2.51 | 2.64 | 0.13 | 0.458 |
| Workload | 1.93 | 2.07 | 0.14 | 0.385 |
| Work-life Balance | 1.86 | 1.87 | 0.01 | 0.957 |
| Occupational Self-Efficacy | 4.44 | 4.37 | -0.07 | 0.611 |
| Lived Experience Climate | 4.17 | 3.88 | -0.29 | 0.021 |
| Organizational Climate | 4.35 | 3.97 | -0.38 | 0.007 |
| Peer Status and Influence | 4.05 | 3.58 | -0.47 | <.001 |
| Supervisor Support | 4.04 | 3.55 | -0.49 | 0.004 |
| Supervisor Working Alliance | 4.41 | 4.16 | -0.25 | 0.103 |
| Advancement | 4.07 | 3.70 | -0.37 | 0.023 |
| Training | 4.02 | 3.62 | -0.4 | 0.003 |
| Exemption Process | 2.96 | 3.10 | 0.14 | 0.449 |
| Certification Process | 4.30 | 4.23 | -0.07 | 0.632 |

*Note.* This comparison includes only peers examining differences in workplace perceptions by supervisor type (peer supervisor vs. non-peer supervisor). Mean differences were calculated as non-peer supervisor group mean minus peer-supervisor group mean. Intent to leave was measured using three items scored on a 1–5 scale ranging from 1 (Extremely Unlikely) to 5 (Extremely Likely).

P values indicate the probability that the observed difference could have occurred by chance if there were truly no difference between peers and supervisors. Values less than .05 are generally considered statistically significant, meaning the likelihood that the observed difference is due to chance is less than 5 percent.
*Source*: Mixed-Methods Survey

## Predictors of Intent to Leave

Table 6 presents results from a multiple regression analysis examining factors associated with peer specialists' intent to leave their positions. The model included workplace and individual-level predictors that were significantly correlated with intent to leave in bivariate analyses. Overall, the regression model was statistically significant and explained approximately 33 percent of the variance in intent to leave, $F(14, 147) = 6.73$, $p < .001$, $R^2 = .391$, adjusted $R^2 = .333$. Burnout emerged as a significant positive predictor of intent to leave ($B = 0.236$, $p < .001$), such that higher levels of burnout were associated with greater intentions to leave. Conversely, advancement opportunities were significantly associated with lower intent to leave ($B = -0.200$, $p = .048$), indicating that access to professional growth and promotion may help retain peer specialists. Other factors, including perceived effectiveness, role clarity, occupational self-efficacy, organizational climate, supervisor support, working alliance, training, exemption status, certification, recovery capital, and peer status and influence, were not independently associated with intent to leave after accounting for the other variables in the model.

**Table 6. Peer Intent to Leave Regression Analysis**

| | | | | 95 percent CI | | |
|---|---|---|---|---|---|---|
| Variable | B | SE | t | LL | UL | p |
| Constant | 3.926 | 0.591 | 6.641 | 2.758 | 5.094 | <.001 |
| Effectiveness | -0.121 | 0.138 | -0.874 | -0.395 | 0.153 | 0.383 |
| Role Clarity | -0.056 | 0.122 | -0.459 | -0.297 | 0.185 | 0.647 |
| Burnout | 0.236 | 0.064 | 3.675 | 0.109 | 0.363 | <.001 |
| Occupational Self-Efficacy | -0.066 | 0.122 | -0.54 | -0.307 | 0.175 | 0.59 |
| Lived Experience Climate | -0.11 | 0.127 | -0.864 | -0.361 | 0.142 | 0.389 |
| Organizational Climate | 0.092 | 0.124 | 0.742 | -0.153 | 0.337 | 0.459 |
| Peer Status and Influence | 0.035 | 0.108 | 0.328 | -0.178 | 0.249 | 0.744 |
| Supervisor Support | -0.091 | 0.103 | -0.88 | -0.295 | 0.113 | 0.381 |
| Supervisor Working Alliance | -0.056 | 0.103 | -0.548 | -0.259 | 0.146 | 0.584 |
| Advancement | -0.2 | 0.1 | -1.999 | -0.398 | -0.002 | 0.048 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Training | -0.155 | 0.104 | -1.488 | -0.36 | 0.051 | 0.139 |
| Exemption | -0.036 | 0.059 | -0.61 | -0.153 | 0.081 | 0.543 |
| Certification | 0.159 | 0.093 | 1.71 | -0.025 | 0.343 | 0.089 |
| Recovery Capital | -0.055 | 0.126 | -0.435 | -0.303 | 0.194 | 0.664 |

*Note*. B = unstandardized beta; SE = standard error CI = confidence interval; *LL* = lower limit; *UL* = upper limit. P values indicate the probability that the observed difference could have occurred by chance if there were truly no difference between peers and supervisors. Values less than .05 are generally considered statistically significant, meaning the likelihood that the observed difference is due to chance is less than 5 percent. The "Burnout" scale represents a composite of the burnout, workload, and work–life balance subscales, as determined by factor analysis.
*Source*: Mixed-Methods Survey

***Work Setting.*** Appendix 2 Table 13 presents peer specialists' intent to leave by work setting. Workplace settings were grouped into three categories for analysis. Peer-led or consumer-led organizations include peer-run, consumer-run, and family-run organizations. Community-based nonprofit or mixed-model providers include community-based nonprofits, non-peer agencies that operate some peer-led services, universities, and Veteran's Affairs programs delivered in community settings.

Institutional or public sector settings include state, county, or city facilities, hospitals or emergency departments, Veteran's Affairs programs delivered in institutional settings, and other institutional workplaces. A one-way ANOVA indicated that intent to leave did not differ significantly across work settings, $F(2, 159) = 1.20$, $p = .304$. Overall, intent to leave among peer respondents was low and showed little variation by organizational setting. Although differences were not statistically significant, peers working in institutional or public sector settings showed slightly higher average intent to leave compared to peers in other settings. This pattern, while exploratory, may warrant additional attention in future workforce development efforts, particularly in institutional contexts such as hospitals or criminal justice settings where role integration and organizational fit may present unique challenges.

***County Type.*** Appendix 2 Table 14 presents peer specialists' intent to leave across county types. A one-way ANOVA indicated that differences by county type were not statistically significant, $F(2, 159) = 1.75$, $p = .177$, and Bonferroni post hoc comparisons showed no significant pairwise differences (all $p \geq .212$). Peers in rural counties reported slightly lower intent to leave ($M = 1.47$) than those in urban or suburban counties ($M = 1.91$), but overall intent to leave was low across all county types.

***Income.*** Appendix 2 Table 15 presents peers' intent to leave by income. Peer specialists earning less than $40,000 per year reported slightly higher average intent to leave ($M = 1.93$, $SD = 0.92$) compared with those earning $40,000 or more ($M = 1.79$, $SD = 1.01$); however, this difference was not statistically significant, $t(155) = 0.89$, $p = .188$. Overall, intent to leave was low across both income groups, indicating that annual

income alone did not meaningfully influence peers' reported intention to leave their positions.

> *"Due to the low pay and lack of benefits it's hard to have this job as the only source of income, however due to the nature and hours worked its hard to manage another job on top of this one, especially in the position I am in (salary) I make a set amount even though most of the time I work well over 40 hrs a week...I think the pay and benefits should definitely be addressed. Especially given how important of a role peers can have in someone's life."* [Supervisor Open Ended Survey Response]

> *"If I had a single gripe about my work, it would be the rate of pay. I wish the value was recognized through our paychecks rather than in any verbal aspect. The pay for the position sits at the lowest among nearly every consumer direct provider across the board."* [Peer Open-Ended Response]

***Supervisor Type.*** Appendix 2 Table 16 presents differences in intent to leave among peer specialists by supervisor type. An independent samples *t* test indicated that peers supervised by non-peers reported significantly higher intent to leave ($M$ = 2.06, $SD$ = 0.998) compared with peers supervised by peer specialists ($M$ = 1.73, $SD$ = 0.921), $t(160) = 2.15$, $p = .033$.

> *"Working under and with other people in recovery, has been the best co-workers that I've ever had. I think it is because if someone is truly working a program of recovery, then they live by a certain set of spiritual and moral principles. Their life literally depends on mental and spiritual awareness."* [Peer Open-Ended Response]

## *Qualitative Interviews*

### Recovery Peer Specialists

***Recognition, Respect, and Professional Identity.*** While peers demonstrated strong professional identity and job satisfaction rooted in their lived experience, they consistently identified systemic challenges to professional recognition. Compensation emerged as the most pressing concern, with peers reporting "*pay is not a livable wage and does not reflect the importance or impact of the role*." This economic challenge intersected with professional development concerns, as many peers were pursuing advanced degrees that would ultimately take them out of peer work due to higher pay opportunities elsewhere. Stigma from medical providers and, sometimes, non-Peer professionals as well as a lack of awareness about peer roles within upper management

and other departments created additional recognition barriers. Peers reported needing increased awareness of their role within organizational structures, particularly among clinical professionals who remained unclear about peer contributions, noting "*people will kind of disregard your opinion*." Although stigma was not a common barrier listed by peers (*n* = 16), many peers (*n* = 25) expressed resiliency and a positive approach to navigating stigma against individuals in recovery. One peer described: "*there's that opportunity for us to show up not only for ourselves, but for the individuals and... the appropriate language that we use, you know, like not substance use, not junkie, not drug addict.*"

***Role Clarity Amidst Complexity and Role Drift.*** Most peers (*n* = 37) reported clarity in their primary responsibilities, though role complexity emerged as a consistent theme. As one participant noted: *"They're clear and consistent for the most part. I mean, sometimes like I'll get pulled to do different things, but it's for the betterment of the team."* This flexibility, while generally accepted, occasionally led to role drift, particularly when peers were asked to perform medical or administrative duties outside their scope, for example, urine drug screens.

The phenomenon of role drift raised concerns about professional boundaries, with one peer explaining: "*They were putting things like case management on us and then calling us hybrids… I really fought against that... it really kind of went against my grain as a peer in the purest form."* The distinction between role clarity at the individual versus leadership level emerged as critical, with peers understanding their responsibilities while leadership sometimes lacked clarity about appropriate peer responsibilities. For example, one peer explained, "*the roles and responsibilities are pretty clearly laid out on paper. Yeah, but what it actually looked like in action is a lot different.*"

***Differing Integration Across Settings.*** Integration experiences varied significantly across organizational contexts. Peers in RCOs and peer-led facilities reported full integration "by nature" of their organizational structures. The majority of peers (*n* = 37) across settings described being fully integrated, though some (*n* = 7) experienced partial or unclear integration, particularly in traditional healthcare settings. One peer described the need to be part of the bigger team, "*just be part of the staff, part of everyone else...we need their support*."

The quality of integration directly impacted professional value perception. One peer articulated this tension: *"We're non-clinical, we're considered non-clinical, but I'll tell you, I think we're the glue that really holds programs together and keeps the clients wanting to be involved and keep them coming back."* However, integration challenges persisted, with another peer reporting: *"We're kind of sometimes treated like the grunts of the offices, whereas like if someone doesn't want to do something, they'll have the peer do*

*it."*

***Training as Foundation with Critical Gaps.*** The CRPS training emerged as foundational. Most responses (*n* = 27) viewed CRPS training as good but emphasize the importance of on the training, explaining "*the real training is on the job experience*." Peers particularly valued hands-on, experiential hours and existing lived experience as essential components of preparation. However, significant gaps emerged in training content and accessibility.

Access challenges included limited availability of no-cost trainings and continuing education units (CEUs), with one peer admitting, *"I scramble at the end of the year,"* explaining how difficult it is at times to complete the required CEs. Peers reported confusion about which trainings counted for CEUs and often used personal time off (PTO) to attend trainings when organizational support was lacking.

Training content gaps identified included: MAT and risk reduction approaches, co-occurring mental health disorders, de-escalation and crisis intervention, documentation requirements, vicarious trauma and burnout prevention, ethics and boundaries, and self-care strategies. Motivational Interviewing (MI) and Wellness Recovery Action Plan (WRAP) consistently emerged as the most valuable supplementary trainings, with NAMI trainings repeatedly described as "excellent."

The importance of self-care training received particular emphasis, with one peer stating: *"I think that something that needs to be incorporated into trainings is really highlighting self-care is a job requirement... specifically using your lived experience, drawing upon that can be very emotionally taxing."*

### Supervisors and Administrators

***Navigating Dual Roles and Workforce Quality.*** Interviewed supervisors, all having lived experience themselves, navigated complex dual identities as both recovery allies and organizational representatives. One supervisor articulated this balance: *"Even though I'm doing the supervision, it's not that I'm above them. I am them."* This duality created unique challenges in balancing empathy with accountability, particularly regarding documentation and professional boundaries.

Both supervisors and administrators expressed concerns about workforce quality and retention. One supervisor reflected: *"Retention is definitely hard. So, another thing I've noticed too is, you know, getting, I hate to say it, cause I love peers, but getting quality peers [is a challenge]."* Another noted specific challenges: *"Reliability issues, time management issues, you know, not treating all participants the same, no matter what walk of life they come from."*

The ongoing nature of recovery work impacted job performance, as one supervisor explained: *"When you're in recovery, it's a lifelong process. If you're not continuously working on yourself to be the best version, to work on your character defects, all that stuff, it's going to show in your behavior at work."*

***Training Infrastructure and Quality Concerns.*** Supervisors and administrators noted that while CRPS training provided a foundation, it did not adequately prepare peers for the actual work demands, with one supervisor describing it as "*it's like a drop in the bucket. There's not enough that can prepare you with what they're going to be faced with and challenged with.*" The 500-hour requirement was deemed essential for hands-on experience yet concerns about training quality and availability persisted.

One supervisor noted the scarcity of quality training: *"It is a great training [CRPS 40-hour] when, you know, we can find ones that are available because they are getting very, very scarce to find. A lot of people lost like training funding."* Another raised concerns about potential harm during the training period: *"The struggle is people would bring in a peer worker, but they wouldn't get them trained until the very end. So, they're already doing work. So, if they're going to do any damage, they're going to do the damage already."*

The emotional toll of peer work contributed to turnover, with supervisors noting: *"They're trained well, but you just never know until you're actually like kind of in it and doing it... sometimes you can't teach people to have like the heart for it."* An administrator added, *"People just get burnt out. They start to get resentful. They don't want to show up to work because they know they're going to have a hard day. It's a hard job. It's draining emotionally."*

Supervisors specifically recommended the Floridians in Recovery and NAMI curriculum as the "gold standard," while administrators emphasized the need for enhanced self-care training: *"I think there should be more of an emphasis in the peer training on self-care and wellness because I see a lot of burnout with peers."*

***Healthcare Integration and Culture Change.*** Stigma within clinical settings still persists. An administrator reflected: *"When I was doing direct service as a peer... with certain providers, mainly clinical providers, I will say they don't necessarily see it as a professional role."* Despite this, administrators remained committed to workforce expansion*: "We need to implement as many as we can because honestly, like the value of having somebody who's got that lived experience... there's just nothing more valuable than that."*

### Cross-Cutting Themes and Convergent Perspectives

Across recovery peer specialists, supervisors, and administrators, cross-cutting themes and perspectives arose including (1) recognition and professional legitimacy, and (2) job satisfaction paradox.

***Recognition and Professional Legitimacy.*** Across all stakeholder groups, the need for professional recognition emerged as fundamental, with one CEO explaining, "*We're using our shared experiences from an expertise model*." Participants called for elevating *"the profession's status to be as respected and sought after as social work or therapy."* This included ensuring peers have *"a true voice at the table, not just a seat—move from being tolerated to being valued partners in conversations and decision-making."*

The need for workforce education was emphasized, with participants recommending that clinicians, doctors, and therapists learn about peer roles during their degree programs. Organizations demonstrating successful integration, specifically, NAMI, South Florida Wellness Network, and Thriving Mind South Florida, were recognized for comprehensive training programs and supportive supervision structures.

***The Job Satisfaction Paradox.*** Despite systemic challenges, peers (*n* = 38) expressed profound job satisfaction rooted in their unique contributions. The pride in sharing lived experience and the "unique connection" with individuals/participants/people served created meaning that transcended economic limitations. Peers recognized their lived experience as a "unique asset" distinguishing them from providers without such experience.

This satisfaction paradox, high meaning despite low compensation, created workforce vulnerability, with some peers pursuing advanced degrees that would ultimately remove them from peer work. This represents an opportunity for professional advancement on one hand, but a threat to the long-term viability of the peer profession in the absence of broader peer workforce growth and a clear, non-clinical peer career ladder option on the other.

## Objective 2b. An Examination of Reasons for Exemption from Disqualification

### *Process and Policy Review*

An examination of Florida peer certification requirements relative to SAMHSA "National Model Standard for Peer Support Certification" (SAMHSA, 2023) (see Table 7) by national subject matter experts reveals multiple points of divergence from key aspects of

SAMHSA-established best practice standards[79].

**Table 7. Florida – SAMHSA National Model Standard Crosswalk**

| | SAMHSA National Model Standards | Florida Peer Certification Requirements (§397.417, §435.07) |
|---|---|---|
| **Where Background Checks Occur** | • Should be conducted by employers, not certification bodies.<br>• Certification programs should NOT embed background checks. | • Required for certification AND employment.<br>• Conducted by DCF/AHCA, not the credentialing body.<br>• Mandatory abbreviated version of the Level 2 fingerprinting (FDLE + FBI). |
| **Purpose/Role of Checks** | • Not recommended that checks be used at certification level.<br>• When unavoidable then use self-disclosure first; background checks only for confirmation. | • Screening is a gateway requirement for becoming or working as a peer specialist.<br>• Mandatory arrest-notification enrollment. |
| **Disqualifying Offenses** | • Limit to risk-based offenses only: sexual violence, crimes against children, serious violent crimes<br>• Exclude drug/alcohol offenses and non-violent felonies from certification decisions. | • Broad statutory list including violent felonies, sexual offenses, child abuse/neglect, vulnerable adult exploitation, financial/identity crimes, certain felony drug offenses (Ch. 893)<br>• ANY felony within past three years is disqualifying. |
| **Automatic Disqualifiers** | • Discourages blanket bans.<br>• Encourages individualized review. | • Extensive automatic statutory bans.<br>• 3-year felony exclusion applies even to non-violent offenses. |

| | | |
|---|---|---|
| **Exemption/Waiver Pathways** | • Case-by-case review recommended.<br>• Emphasize rehabilitation and suitability. | • Formal §435.07 exemption required.<br>• Requires: notarized letters, recovery/treatment documentation, court records.<br>• Burden of proof: "clear and convincing evidence."<br>• Administrative Law Judge appeal pathway available. |
| **Workforce Mobility/Portability** | • Designed to improve reciprocity and portability across states. | • Relies on state-specific statutory lists and exemption pathways, which limits portability. |
| **Overall Alignment** | • SAMHSA aims for low-barrier, equitable, employer-based background check practices. | • High-restriction, legally embedded screening system<br>• Moderate misalignment with SAMHSA standards. |

Further, three consistent themes emerged from a state-by-state analysis of background screening, disqualification, and exemption policies and procedures across all 50 U.S. states:

1. *Certification-level background checks are rare.* Only six states —Florida, Ohio, Oklahoma, Texas, Nebraska, and New Hampshire—require background checks during certification, diverging from national best-practice standards. Most states rely on employer- or facility-level screening, where individualized review is more feasible and less exclusionary.

2. *Waiver and exemption systems are the primary equalizers.* States such as Missouri, Idaho, Oregon, Mississippi, Arkansas, Ohio, and Georgia demonstrate that structured, transparent waiver systems allow justice-involved individuals to reenter the peer workforce while still addressing safety concerns.

3. *Automatic disqualifiers appear mostly in provider-level regulations, not certification***.** Nationally, disqualifying offense lists are limited where certification is concerned. States that do rely on such lists use them sparingly and pair them with review boards, time-limited exclusions, or rehabilitation-based criteria.

Relative to other U.S. states and national benchmarks, Florida:

- Uses more restrictive, front-end screening criteria than the majority of states.
- Embeds statutory disqualifiers at the certification stage, instead of relying on employer-level screening.
- Requires additional documentation, including, notarized support letters, and detailed relapse histories not required elsewhere.
- Coordinates a multi-tiered appeals process that can delay certification access.
- Lacks a fully developed Review Board structure that includes peer representation and behavioral-health system expertise.

Peer ratings of the exemption process are reflective of some of the potential risks and consequences flagged by state and national subject matter experts in their reviews.

## *Secondary Data Analysis*

DCF's reported data (Table 8) demonstrates a total of 86 applications for exemption from recovery peer certification disqualification over the past 3.5 years. Requests increased year over year, with the highest volume of requests (n = 44) observed in FY 2024. In FY 2025, 22 requests were received within the first six months of the fiscal year. From FY 2022 through FY 2025 year-to-date (YTD), nearly 82.6 percent (n = 71) of exemption requests have been granted by DCF. An average of 10.5 percent across fiscal years of exemption requests have been denied across the years reported. The remaining were either cancelled or pending.

Reasons for denials were noted by the Background Screening Program to include the nature of the offense, such as violence or children, recency of offense, and insufficient information provided by applicant to make a determination. Data pertaining to the frequency of reasons for denial were not available at the time of this report.

**Table 8. DCF Exemption from Disqualification Determinations**

| | FY 2022 | FY 2023 | FY 2024 | FY 2025 YTD | Total |
|---|---|---|---|---|---|
| | **n (percent)** | **n (percent)** | **n (percent)** | **n (percent)** | **n (percent)** |
| Granted | 10 (100) | 8 (80) | 35 (79.5) | 18 (81.8) | 71 (82.6) |
| Denied | — | — | 7 (15.9) | 2 (9.1) | 9 (10.5) |
| Cancelled | | 2 (20) | 2 (4.5) | 1 (4.5) | 5 (5.8) |
| Under Review | — | — | — | 1 (4.5) | 1 (1.1) |
| **Total Applications** | **10** | **10** | **44** | **22** | **86** |

*Source: DCF*

## *Mixed Method Survey*

The exemption process, as measured in the mixed-method survey, reflects peers' and supervisors' perceptions of the ease, clarity, and fairness of obtaining an exemption from disqualification. Across the full peer sample, peers reported slightly higher perceptions of the exemption process than supervisors ($M$ = 3.02 vs. 2.60; $p$ = .028), though perceptions of the exemption process were generally much lower when compared to other survey scales. When examining peer perception of the exemption process by supervisor type, differences were not significant ($M$ = 2.96 for peer-supervised vs. 3.10 for non-peer-supervised; $p$ = .449), indicating that supervisory type does not meaningfully influence peer perceptions of exemption procedures.

> *"We lose out on a lot of amazing candidates with lived experience because they have lived experience and their use led to them having criminal charges" [Supervisor Open-Ended Response]*
>
> *"The exemption process can be retraumatizing and takes an exorbitant amount of time for the paperwork to be processed" [Peer Open-Ended Response]*
>
> *"Exemption process for level 2 DCF clearance is ridiculous, and almost acts as a deterrent for people with lived experience, as most of us don't have a clean record" [Peer Open Ended Response]*

## *Qualitative Interviews*

### Recovery Peer Specialists

***Certification and Exemption Challenges.*** While many peers described the certification process as "*not difficult*," systemic barriers created significant challenges. The 500-hour requirement emerged as both essential and burdensome, with perspectives varying by experience level.

One peer reflected on the basic certification requirements: *"The paperwork, it is what it is. I mean, we're getting a certification. We should be background checked. We should have these referrals and working hours like these are things that need to be proven."* However, another peer highlighted access barriers: "*The 500 hours and making it so difficult for them to become peer specialists... a lot of times they can't get those hours and they have to volunteer and they're trying to work a full-time job*."

The Level II background check requirement and exemption process represented

particularly significant barriers. The exemption process was consistently described as "*tedious*," "*burdensome*," "*costly*," and "*invasive*," deterring qualified individuals from entering the workforce. Participants reported that paperwork was consistently lost after submission, communication regarding the exemption process was poor, and the 180-day timeline for completion was insufficient. The requirement to document their entire criminal history, at times "*spanning 20-30 years*" was viewed as unnecessarily "*retraumatizing*."

### Supervisors and Administrators

***Systemic Barriers and Hiring Challenges.*** Both supervisors and administrators identified the Level II background check and exemption process as the primary barrier to workforce development. The process created significant hiring delays and deterred qualified candidates from entering the workforce.

One supervisor described the challenge: *"They have this wonderful lived experience, but I'm like, OK, how much lived experience do they have that I'm not going to be able to hire them."* An administrator illustrated the operational impact: *"We interview someone, we love them, we're ready for them. Their clearinghouse comes back and…by the time someone has already gotten this exemption, we might have had to have hired someone else."*

The retraumatizing nature of the exemption process drew particular criticism, with one supervisor stating: *"The background screening process has gotten better, tremendously better, I will say that. But it is excruciating for some people. You know, I don't understand why we have to go back 20-30 years. I don't understand why we need juvenile records."*

Financial barriers compounded these challenges, including certification fees and costs associated with obtaining legal documentation, which several noted being expensive. Communication challenges with the FCB, including delays, lost applications, and case manager turnover, further complicated the process.

## Objective 3: Program and Funding Models

Models for embedding and financially sustaining recovery peer support services in ROSC in Florida and across U.S. states were examined through a review of the literature and state processes and policies. Findings from secondary data analysis, the mixed methods survey, and qualitative interviews with implications for program models are further highlighted and integrated throughout. Service-level expenditures were also examined to understand the financial mechanisms operating within Florida's publicly funded substance

use disorder programming through Florida's seven MEs.

## *Program Models*

### Florida Process and Policy Review

The Florida Department of Children and Families Office of SAMH has established several evidence-based, peer-embedded strategic imperatives which are actively underway in Florida communities. Priority and implemented programming include Hospital Bridge Programs, Jail Bridge Programs, CORE Networks, and RCOs. Bridge Programs intervene at critical junctures to identify individuals with substance use disorders, initiate treatment in emergency departments or jail, and connect individuals to community treatment and recovery services upon discharge or release. CORE Networks leverage recovery peer navigators and strategic community partnerships amongst first responders, hospital emergency departments, and community treatment providers to guide individuals with opioid use disorder across care transitions and into long-term, comprehensive care. RCOs are peer-led community non-profit organizations providing peer recovery services, advocacy, and education in community. RCOs may function in partnership with healthcare treatment services but are intentionally distinct and non-clinical in nature, providing peer-based recovery support before, during, and after treatment, and serving as a stable resource in the community regardless of where an individual receives care along the treatment continuum. According to SAMH reports, 52 Florida hospitals and 24 Florida jails were operating bridge programs in FY 2024–2025, CORE Network support mechanisms were available to all 67 Florida counties by the end of 2025, and 28 RCO locations were operating in 2024–2025[47].

### Secondary Data Analysis

Analyses of secondary FASAMS data were conducted to explore effectiveness within several DCF peer-embedded model programs including hospital, jail, and RCOs.

#### *CRPS vs Non-CRPS Service Duration and Intensity in Medical Hospital Settings*

Among individuals who received any clinical treatment service in a medical hospital setting (n = 63) within the study period, 48 had CRPS involvement and 15 did not. The distribution of clinical treatment engagement was positively skewed in both groups. Among non-CRPS-involved service recipients, the median duration of engagement was one month (IQR = 3.0), compared to two months (IQR = 2.0**)** among CRPS-involved service recipients. The difference in clinical treatment service duration was not statistically significant (U = 297.00, Z = −1.05, p = .293) with a small-to-moderate estimated effect size (r = .13). Clinical service utilization was also highly skewed in both

CRPS-involved and non-CRPS-involved service recipient groups. The median number of clinical services was three (IQR = 9.0) among non-CRPS-involved service recipients and the (IQR = 5) among CRPS-involved service recipients. No statistically significant difference was observed in service intensity between groups (U = 337.50, Z = −0.37, p = .713).

Overall, given the small subsample size of individuals with medical hospital-based services, the statistical power was low, and findings of non-significance should be interpreted with this in mind. Further, limitations of the data in their current form restrict the ability to establish temporal order, control for the specific type of clinical treatment service received, and account for dynamic transitions along the continuum of substance use disorder care. Future analyses should address these limitations.

### *CRPS vs Non-CRPS Service Duration and Intensity in Jail/Prison Settings*

Among service recipients receiving any clinical treatment service in a jail or prison setting (n = 437), 217 service recipients had CRPS involvement and 220 did not. Non-CRPS-involved service recipients had statistically significant, longer engagement compared to CRPS-involved service recipients (U = 6,862.50, Z = −13.31, p < .001). The effect size was large (r = .64), suggesting a substantial difference in non-CRPS service recipient clinical treatment service duration amongst those who established with a CRPS within the jail or prison setting. A similar pattern was observed for clinical treatment service utilization. Non-CRPS-involved service recipients had significantly greater service intensity compared to CRPS-involved service recipients (U = 7,452.00, Z = −12.61, p < .001). The magnitude of this association was also large (r = .60), suggesting higher clinical treatment volume among non-CRPS justice-involved service recipients.

Within the jail/prison context, CRPS involvement was associated with shorter treatment duration and lower clinical service utilization compared to non-CRPS-involved service recipients. While this finding is contrary to what was expected, it is possible that the complement of CRPS engagement actually accelerates treatment response and therefore a shorter duration and volume of treatment may be required. The absence of clinical-level data limits the ability to examine this directly. Future analyses should examine this, as well as address the before noted limitations with regards to temporal order, the nature of services, and movement from receipt of clinical treatment services in jail/prison versus in the outpatient setting upon release.

### *CRPS Service Duration and Intensity Across Service Settings*

Though it may not be unique to them, a potential advantage of RCOs is the ability to

function across settings in the community. While service-level data cannot be attributed specifically to those provided by an RCO-based CRPS, preliminarily, the association of service setting with treatment service engagement and duration can be examined and inferences drawn.

Among CRPS-involved service recipients receiving clinical treatment services, 68.6 percent (n = 13,210) received services solely on provider premises, while 31.4 percent (n = 6,037) received services in a community setting or in the recipient's home at least once. Treatment duration was compared between CRPS-involved service recipients who received services in community setting or in the recipient's home and CRPS-involved service recipients who received clinical treatment services solely on provider premises. A Mann-Whitney U test showed CRPS-involved service recipients who received clinical treatment services in a community setting or the recipient's home had significantly longer engagement compared to those with CRPS involvement exclusively on provider premises ($U = 35{,}689{,}594.50$, $Z = -12.64$, $p < .001$). The effect size was small ($r = .09$), suggesting that service setting contributes to engagement but is not the primary driver of treatment duration.

Service intensity was similarly compared between CRPS-involved service recipients who received clinical treatment services in a community setting or the recipient's home and CRPS-involved service recipients who received CRPS services solely on provider premises. A Mann-Whitney U test showed CRPS-involved service recipients who received clinical treatment services in a community setting or the recipient's home also had slightly higher clinical treatment service utilization compared to those receiving services only on provider premises ($U = 38{,}835{,}941.00$, $Z = -2.97$, $p = .003$). However, the magnitude of this difference was again small ($r = .02$), indicating service setting contributes to service intensity albeit is not the primary driver.

Another potential advantage of RCOs is the flexibility to move across settings, rather than being restricted to a single site, such as a medical hospital. Again, while not able to examine this specific to RCOs, this general premise can preliminarily be examined. Among CRPS-involved service recipients, most received services within a single setting type at 84.6 percent, while 14.1 percent received services in two settings, 1.2 percent in three settings, and 0.1 percent in four settings. Overall, CRPS-involved service recipients had a median treatment duration of two months (IQR = 3.0), and duration of clinical treatment engagement increased substantially among those exposed to multiple service settings. Duration increased progressively with the number of setting types, with recipients receiving services in one setting having the lowest mean rank for duration at 9,199, followed by two settings at 15,841, three settings at 19,014, and four settings at 20,109. The Kruskal–Wallis test revealed a statistically significant association between number of setting types and duration of engagement ($H(3) = 4355.57$, $p < .001$), with a

large effect size ($\eta^2 \approx .21$). This effect size suggests approximately 21 percent of the variance in engagement duration was associated with cross-setting exposure.

Across all CRPS-involved service recipients, the median number of clinical treatment services received was four (IQR = 13.0). Notably, service utilization was highly skewed, with a subset of service recipients receiving substantially higher service volumes. A similar gradient in clinical treatment service utilization was observed as in the duration analysis. Mean ranks increased steadily across service setting groups. Service recipients receiving services in one setting had the lowest mean rank for service utilization at 9,506.85, followed by those receiving services in two settings at 14,102.55, three settings at 17,766.52, and four settings at 18,797.31. The association between number of setting types and total clinical treatment services received was statistically significant ($H(3) = 2021.31$, $p < .001$) with a moderate effect size ($\eta^2 \approx .10$). This effect size indicates that approximately 10 percent of the variance in service utilization was associated with cross-setting CRPS involvement.

Taken together, these findings suggest that the flexibility to deliver CRPS across services is associated with clinical treatment service engagement – both intensity and duration.

### Mixed Method Survey

As reported, CRPS with supervisors who are themselves peers was significantly associated with indicators of integration and other organizational considerations, as well as CRPS retention intention in this study. More specifically, peers with non-peer supervisors reported a slightly higher intent to leave compared with peers with peer supervisors ($M = 2.06$ vs. $1.73$; $p = .033$), although perceived effectiveness and recovery capital did not differ significantly between the groups. Significant differences emerged across several workplace characteristics. Peers with peer supervisors reported more favorable perceptions of the lived experience climate ($M = 4.17$ vs. $3.88$; $p = .021$), organizational climate ($M = 4.35$ vs. $3.97$; $p = .007$), peer status and influence ($M = 4.05$ vs. $3.58$; $p < .001$), supervisor support ($M = 4.04$ vs.$3.55$; $p = .004$), advancement opportunities ($M = 4.07$ vs. $3.70$; $p = .023$), and training ($M = 4.02$ vs. $3.62$; $p = .003$).

Establishing recovery peer programs with experienced CRPS themselves serving as supervisors is likely to mitigate turnover risks amongst the peer workforce, which is essential for integration, continuity of supports and services for individuals, and ultimately effectiveness, and therefore should be considered as an important component of program model development and implementation. To this end, post hoc data provided by DCF demonstrate a rising number of peers functioning in supervisory

roles, increasing from 73 in FY 2022–2023 to 103 in FY 2023–2024, representing a 41 percent increase, and to 120 in FY 2024–2025, representing a 17 percent increase.

## *Funding Models*

### Process and Policy Review

#### National

Peer recovery support services in the United States are financed through a combination of federal, state, local, and private funding streams, with grants remaining a foundational entry point[80,81]. The Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG)[82], administered by SAMHSA, is the cornerstone of federal support, providing flexible funding that enables states to integrate peer services. In addition, state appropriations, local government grants, and private or community-based foundations often provide more accessible, locally aligned funding, particularly for peer-led organizations. A survey of 27 states found that the most prevalent funding sources were state funds at 85.2 percent; the Mental Health Block Grant at 77.8 percent; the Substance Use Prevention, Treatment and Recovery Support Block Grant at 63.0 percent; State Opioid Response (SOR) discretionary funds at 51.9 percent; Medicaid and APRA, each at 44.4 percent; and Opioid Settlement Funds at 40.7 percent[81,83]. However, grants are inherently time-limited, competitive, and administratively complex, making them insufficient for long-term sustainability without additional, ongoing funding mechanisms.

Braided funding has emerged as the best practice for sustaining peer services at scale[80,81]. States such as Missouri, Wisconsin, and Illinois demonstrate the power of blending SUPTRS BG funding with state general revenue, discretionary opioid response grants, local investments, and Medicaid reimbursement[80,83]. This approach allows programs to maintain both billable peer services and essential non-billable functions, including workforce development, supervision, infrastructure, outreach, and community engagement. RCOs and local governments are key partners in these efforts, helping embed peer services in community priorities, mobilize support, and advocate for sustainable funding structures.

Medicaid is recognized as a critical but underutilized mechanism for supporting recovery peer services across the United States[80,81]. While nearly all states authorize Medicaid reimbursement for peer support, utilization remains limited, often representing only a small fraction of Medicaid beneficiaries with substance use disorders. Fee-for-service billing structures, variable reimbursement rates, and supervision requirements create significant barriers to scale, particularly for peer-run organizations. Managed care models offer additional flexibility when peer services are explicitly included in contracts,

and emerging private insurance coverage, supported by Mental Health Parity and Addiction Equity laws, provides incremental opportunities to expand reach. Still, administrative complexity, limited infrastructure, and restrictive billing requirements continue to suppress participation and access.

Findings from a 50-state scan of state Medicaid programs found reimbursement rates for individual recovery peer services to largely cluster between $12 and $20 per 15 minutes, with several states exceeding $20, including $23.17 in Missouri, $24.78 in Oregon , $24.94 in New Hampshire, and up to $36.32 in New York[83]. Florida reimburses $9.75 per 15-minute unit for individual peer recovery support services under Medicaid. Compared nationally, this rate is well below the majority of states and places Florida in the lower tier of Medicaid reimbursement for peer-delivered substance use recovery services. Florida's rate is comparable only to the lowest-paying states, including Oklahoma ($9.75), Pennsylvania ($10), Tennessee ($10), Wyoming ($9), and South Carolina ($5.98). Cross-state analyses indicate that sustainable peer recovery ecosystems require intentional coordination across multiple funding sources rather than reliance on a single mechanism[80]. States that successfully sustain peer services invest in Medicaid-recognized benefits while strategically leveraging grants, opioid settlement funds, state appropriations, and local revenue. They also prioritize infrastructure, workforce pipelines, and statewide advocacy networks to strengthen organizational capacity and reduce fragmentation.

Overall, national evidence underscores that long-term viability depends on braided funding approaches, community engagement, policy alignment, and investments that support both billable and non-billable peer functions.

**Florida**

***Public funding for uninsured or underinsured.*** Administered through the Florida DCF Office of SAMH, Florida's public substance abuse services are largely supported through a braided funding structure that combines state general revenue, federal block grants, specifically, Substance Abuse Prevention and Treatment Block Grant, Community Mental Health Services Block Grant, federal discretionary grants, specifically, State Opioid Response, or SOR, grant, and funds from the Opioid Settlement Trust, with funds flowing through the Office of Recovery and the state's seven MEs.[46]

Significant Florida investments in peer recovery support are evident across these funding streams. For example, in FY 2023–2024, $13 million from the legislature was allocated specifically for peer workforce development, enabling the hiring of additional CRPSs and the expansion of RCOs. Florida's $3.1 billion opioid settlement funds are

distributed across three main streams: State, which flows from the General Appropriations Act through the Department of Children and Families; Regional, which passes through state agencies and Managing Entities to both qualified and non-qualified counties; and City/County, which is administered locally by opioid administrators for counties and municipalities. Notable highlights of opioid settlement fund utilization in FY 2024–2025 and FY 2025–2026 include peer support and RCO expansion totaling $18.7 million and the development and implementation of CORE networks totaling $63.6 million, hospital bridge programs totaling $8 million, jail-based MOUD bridge programs totaling $4 million, and court diversion programs totaling $14 million, all with peers serving an essential function in promoting and navigating recovery across transition points and systems. Over $58.4 million was allocated for primary prevention and Naloxone overdose prevention and over $51.2 million for treatment and recovery support services.

Recovery support is a covered service within Florida's SAMH Community Substance Abuse and Mental Health Services provided by a Certified Recovery Peer Specialist (F.A.C. 65E-14.021).[73] This service stands in administrative code as "nonclinical activities that assist individuals and families in recovering from substance use and mental health conditions" with activities including "social support, linkage to and coordination among service providers, life skills training, recovery planning, coaching, education on mental illness and substance use disorders, assisting individuals using digital therapeutics approved by the United States Food and Drug Administration, and other supports that facilitate increasing recovery capital and wellness contributing to an improved quality of life." While administrative code (F.A.C. Chapter 65D-30) does not explicitly mandate supervision by a licensed clinical provider for CRPS-delivered recovery support services, ambiguity in supervision expectations has led to inconsistent interpretation across managing entities and providers, affecting program development, causing administrative burden, and influencing reimbursement practices.[74]

***Medicaid*.** Administered by the Florida AHCA, Florida's Statewide Medicaid Managed Care (SMMC) system is funded through a combination of federal medical assistance match funds, in FY 2025-2026 at a rate of 57.22 percent and state General Revenue Funds. [75, 76,77] As of July 2025, peer recovery support services are covered as an In Lieu of Service (ILOS) for all 9 plans:

- (7) Comprehensive Plus Plans,
- (1) Select Comprehensive Long-Term Care Plus Plan,
- (1) Managed Medical Assistance+ Specialty Plan

Managed Medicaid Assistance plans in Florida's SMMC. "Self-help/Peer Services" are substituted for "Psychosocial Rehabilitation" services within the Behavioral Health

Community Support Services Coverage Policy.[78]

Through AHCA, Florida counties are able to draw federal Medicaid funds for substance abuse services, including peer recovery support, through the Local Medicaid Match Certification program. Counties enroll in Medicaid as a Community Behavioral Health Services provider and contract with providers to offer these services. In 2026, individual peer recovery comprehensive community support services are reimbursed at a rate of $9.75 per quarter hour for individual and $2.44 per quarter hour for group, with a maximum allowable of 120 units per fiscal year each.

Because DCF serves as the payer of last resort, vulnerabilities in data, including FASAMS were identified that could threaten long-term viability, creating a risk of drawing down DCF funds when Medicaid eligibility and service coverage exist, particularly in the absence of complete, reliable data and effective controls[48]. Plans are actively in place to address these limitations and risks[48]. At the same time, the COVID-era Medicaid eligibility redetermination pause lapsed in March 2023, translating to fewer Floridians qualifying for Medicaid and a greater likelihood of drawing down DCF funding for receipt of services.

## Secondary Data Analysis

Overall, across a three-year period from July 2022 through June 2025, recovery support service expenditures totaled $18,904,658 (Table 9). Recovery support services accounted for well under one percent of total ME expenditures in each fiscal year, increasing from 0.55 percent in FY 2022–2023 to 0.71 percent in FY 2024–2025, despite notable growth in absolute dollars. While recovery support services constituted a small share of overall spending, expenditures for these services increased by more than 50 percent over the three-year period. An examination by year demonstrated total recovery support expenditure increases from $5.19 million in FY 2022–2023 to $7.81 million in FY 2024–2025, with the largest year-over-year increase occurring between FY 2023–2024 and FY 2024–2025 (32.17 percent). This growth occurred despite a decline in total units of service between FY 2022–2023 and FY 2023–2024, followed by a partial rebound in FY 2024–2025.

**Table 9. Total Managing Entity Expenditures for Recovery Support by Fiscal Year**

| FY | Payment Method (Units*) | Expenditure Amount | Percent of All Expenditures (percent) | Prior Year Difference ($) | Prior Year Difference (percent) |
|---|---|---|---|---|---|
| **2022 – 2023** | 226,128.52 | 5,191,438 | 0.55 | — | — |
| **2023 – 2024** | 108,750.89 | 5,906,620 | 0.54 | 715,182 | 14.00 |

| | | | | | |
|---|---|---|---|---|---|
| **2024 – 2025** | 129,277.55 | 7,806,600 | 0.71 | 1,899,980 | 32.17 |
| **Total** | 464,156.96 | 18,904,658 | 0.60 | — | — |

*Note.* * Units = direct staff time in minutes. Source: DCF

Expenditure growth appeared to outpace changes in service volume, as total Recovery Support expenditures increased by approximately 50 percent between FY 2022–2023 and FY 2024–2025, while total units of service declined by approximately 43 percent over the same period. This reduction in recovery support services billed is in spite of a 37.6 percent increase in the number of CRPSs providing services across DCF-funded programs from FY 2022–2023 (*n* = 857) through FY 2024–2025 (*n* = 1179) according to post hoc data received from DCF.

Within ME year-over-year variability was observed in annual recovery support expenditures, despite the pattern of successive growth amongst MEs in the aggregate. (Table 10) CFBHN, CFCHS, and SEFBHN exhibited successive growth, which paralleled successive increases in units of service. BBHC and LSF were relatively stable in expenditures year-to-year. For LSF, this is in spite of year-over-year reductions in total service units. Surprisingly, annual rises in CRPSs within LSF-supported provider organizations accompanied these yearly reductions in service volume (FY 2022–2023: 219; FY 2023–2024: 276; FY 2024–2025: 303). (Table 11) Both BBCBC and SFBHN experienced a substantial decrease (BBCBS: -71.7 percent; SFBHN: -83.1 percent) in expenditures in FY 2023–2024 but showed signs of full or partial recovery by FY 2024–2025. For SFBHN, changes in units billed do not parallel changes in expenditures and may be best explained by an alternative payment arrangement, retrospective reporting/payment, or a reporting error. SFBHN's reduction of units by over 126,000 from FY 2022–2023 to FY 2023–2024 contributes substantially to the 43 percent observed total deficit across MEs and shadows occurrences of service expansion amongst other MEs when examined in the aggregate. SFBHNs reduction in service volume also appeared to parallel an expanding CRPS workforce according to the same data received by DCF post hoc (FY 2022–2023: 48; FY 2023–2024: 64; FY 2024–2025: 87; see Table 11).

**Table 10. Recovery Support Expenditures by ME***

| ME * | Payment Method (Units **) | | | Total Expenditures ($) | | |
|---|---|---|---|---|---|---|
| | *FY 2022-2023* | *FY 2023-2024* | *FY 2024-2025* | *FY 2022-2023* | *FY 2023-2024* | *FY 2024-2025* |
| **BBCBC ***** | 2,018 | 4,076 | 4,630 | 320,584 | 90,627 | 119,400 |
| **BBHC** | 19,536 | 19,590 | 15,396 | 1,168,708 | 1,205,511 | 1,052,797 |
| **CFBHN** | 6,119 | 6,864 | 8,272 | 801,132 | 1,161,013 | 1,432,043 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **CFCHS** | 14,925 | 20,478 | 33,834 | 511,852 | 1,008,178 | 1,576,390 |
| **LSF** | 25,067 | 20,282 | 15,870 | 616,321 | 794,105 | 665,296 |
| **SFBHN *** ** | 127,473 | 943 | 2,543 | 354,677 | 59,917 | 629,522 |
| **SEFBHN** | 30,991 | 36,519 | 48,732 | 1,418,165 | 1,587,269 | 2,331,152 |
| **Total** | 226,129 | 108,752 | 129,277 | 5,191,439 | 5,906,620 | 7,806,600 |

*Note.* * ME = Managing Entity. ** Units = direct staff time in minutes. *** BBCBC = Big Bend Community-Based Care/ Florida Health Network (NWFHN); SFBHN = South Florida Behavioral Health Network Thriving Mind South Florida. Source: DCF

**Table 11. Number of CRPSs by ME***

| ME * | *FY 2022-2023* | *FY 2023-2024* | *FY 2024-2025* |
|---|---|---|---|
| **BBCBC**** | 56 | 51 | 63 |
| **BBHC** | 135 | 238 | 193 |
| **CFBHN** | 180 | 230 | 267 |
| **CFCHS** | 35 | 62 | 103 |
| **LSF** | 219 | 276 | 303 |
| **SFBHN**** | 48 | 64 | 87 |
| **SEFBHN** | 184 | 163 | 163 |
| **Total** | 857 | 1084 | 1179 |

*Note.* * ME = Managing Entity. ** BBCBC = Big Bend Community-Based Care/ Florida Health Network (NWFHN); SFBHN = South Florida Behavioral Health Network Thriving Mind South Florida. Source: DCF

Additional information is needed to fully appreciate the factors driving the reduction in service units, particularly in light of an expanded CRPS workforce. While presumed inconsistency or error in data reporting limits the ability to draw definitive conclusions, recovery support expenditure growth is suspected to be driven by rises in unit rates rather than service expansion.

An examination of recovery support services revealed services to be overwhelmingly delivered through fee-for-service payment methods, specifically a payment method in which services are reimbursed according to a negotiated fee schedule established by contract or subcontract, accounting for nearly all expenditures in each fiscal year (Table 12)[i]. Capitated payments, specifically an individual-negotiated monthly fee paid for an

enrolled individual regardless of whether services are received during that period represented a minimal share of spending in FY 2023–2024 totaling 67 percent, and FY 2024–2025 totaling 32 percent. Median payment rates for recovery support services provided at the individual, specifically, level increased from $50.83 in FY 2022–2023 to $61.04 in FY 2023–2024, remaining stable in FY 2024–2025. Median payment rates for recovery support services provided to a group of participants increased modestly from $12.74 to $15.39 over the same period and then stabilized. However, substantial variability in reported payment rates suggests potential inconsistency in unit definitions or data reporting, and caution is advised with interpretation.

**Table 12. Recovery Support Expenditures by Payment Method and Fiscal Year**

| | Payment Method | | Individual Rates ($, Interquartiles**) | | | Group Rates ($, Interquartiles**) | | |
|---|---|---|---|---|---|---|---|---|
| **FY** | *Method* | *percent* | *Min* | *Max* | *Median* | *Min* | *Max* | *Median* |
| **2022–2023** | Fee for Service* | 100.00 | 8.78 | 80.50 | 50.83 | 8.77 | 16.50 | 12.74 |
| **2023–2024** | Fee for Service* | 99.33 | 35.07 | 79.92 | 61.04 | 8.77 | 18.85 | 15.39 |
| | Capitated | 0.67 | 35.18 | 35.18 | 35.18 | — | — | — |
| **2024–2025** | Fee for Service* | 99.68 | 35.07 | 83.82 | 61.04 | 8.77 | 21.00 | 15.25 |
| | Capitated | 0.32 | 61.04 | 61.04 | 61.04 | — | — | — |

*Note.* * Variable payment rates observed in data suggest inconsistent unit definitions and/or other payment methods may be reflected as fee for service. Caution in interpretation is advised. ** Interquartile represents the middle 50percent of payment rates to adjust for *most* outliers. Source: DCF

An examination of initiative-level funding mechanisms, specifically Other Cost Accumulators (OCAs) largely suggests available provider organization flexibility to draw from a variety of funds for recovery support services (Table 13). On average, there were approximately 12–14 OCAs leveraged through each ME per year, with a notable decline in FY 2023–2024 followed by partial recovery in FY 2024–2025. This pattern suggests only a temporary reduction in initiative-based funding. Most MEs maintained a stable or modestly changing number of provider organizations over the three-year period, with the notable exception of SFBHN, which experienced a more considerable decline in provider organization participation between FY 2022–2023 and FY 2023–2024, followed by a partial rebound in FY 2024–2025.

**Table 13. Number of Provider Organizations and Expenditure OCAs* by ME***

| ME* | Number of Provider Organizations | | | Number of OCAs | | |
|---|---|---|---|---|---|---|
| | *FY2022-2023* | *FY2023-2024* | *FY 2024-2025* | *FY2022-2023* | *FY2023-2024* | *FY2024-2025* |
| **BBCBC**** | 2 | 1 | 2 | 7 | 2 | 2 |
| **BBHC** | 14 | 13 | 12 | 19 | 19 | 17 |
| **CFBHN** | 9 | 10 | 11 | 10 | 10 | 10 |
| **CFCHS** | 7 | 9 | 9 | 8 | 13 | 15 |
| **LSF** | 20 | 21 | 21 | 21 | 21 | 19 |
| **SFBHN**** | 7 | 2 | 4 | 16 | 4 | 12 |
| **SEFBHN** | 13 | 15 | 14 | 16 | 13 | 14 |
| **Total** | 72 | 71 | 73 | 97 | 82 | 89 |

*Note.* * OCA = Other Cost Accumulators, ME = Managing Entity. ** BBCBC = Big Bend Community-Based Care/Northwest Florida Health Network (NWFHN); SFBHN = South Florida Behavioral Health Network/ Thriving Mind South Florida. Source: DCF

## *Qualitative Interviews*

Funding uncertainty and inadequate compensation emerged as critical threats to workforce sustainability. Organizations relied on multiple, often unstable funding streams including Projects for Assistance in Transition from Homelessness (PATH) grants and opioid abatement funds. Some organizations were exploring Medicaid billing options, though implementation of this possibility remained unclear.

An administrator captured the compensation challenge: *"Peers already don't get paid what they're worth, honestly, it's a professional position. It's a direct service position that should be paid more… we wish we could pay more,"* further explaining being limited by their funding source and limited budget.

# CONCLUSIONS

Overall, findings indicate that peers are a unique and essential component of Florida's behavioral health workforce. When provided with appropriate training and support, clearly defined roles, strong occupational self-efficacy, and respectful, empowering workplace cultures, peers are able to confidently and effectively support individuals' recovery from opioid-related and other substance use disorders, while also sustaining a self-endorsed purpose in service to others.

## Objective 1: Examine the Effectiveness of Recovery Peer Specialists Supporting Floridians Affected by Substance Use Integrated Summary

Viewed together, secondary data and survey findings indicate that CRPS services represent a highly valued and underutilized behavioral health workforce resource. Substantial limitations in the secondary data, for instance, lack of temporal order, prevent a sound evaluation of whether CRPSs were effective in promoting treatment engagement and continuity of care over time. Limited population reach, demographic disparities, and inconsistent integration with MAT also reflect gaps in workforce deployment, role clarity, and referral infrastructure. These findings highlight opportunities to strengthen peer workforce integration by establishing clearer "warm handoff" pathways, intentional alignment with evidence-based treatment models, and strategic expansion of peer roles to maximize the reach, accessibility, effectiveness, and impact of CRPS services within adult substance use treatment systems.

Importantly, peers' perceived effectiveness is closely linked to clarity of role expectations and confidence in their skills, highlighting the need for intentional implementation and sustained workforce support. Strengthening role definition, professional competency, organizational backing, and opportunities for advancement and credentialing aligns directly with statewide behavioral health workforce impartiality and sustainability goals.

Workforce development strategies should emphasize consistent training, supervision, and support across all counties to maintain high peer effectiveness, rather than targeting specific geographic contexts. Ensuring equitable access to resources and professional development opportunities across urban, suburban, and rural settings will be essential to sustaining a stable, skilled, and effective peer workforce statewide.

## Objective 2: Identify individual/workforce-related, institutional, legal, and procedural barriers to integrating and retaining peer specialists in Florida ROSCs Integrated Summary

This objective identified barriers to integrating and retaining recovery peer specialists in Florida's coordinated systems of care. Taken together, the results of the mixed-methods survey and qualitative interviews closely align with statewide behavioral health workforce priorities focused on capacity building, retention, accessibility, and system sustainability. Identified barriers, such as inadequate compensation, limited advancement pathways, role drift, inconsistent integration across care settings, and insufficient training in MAT, risk reduction, and vicarious trauma. All of these reflect well-documented structural challenges within Florida's behavioral health workforce and underscore the need for coordinated system-level workforce strategies.

The prominence of legal and procedural barriers, particularly the Level II background check and exemption process, highlights a critical misalignment between workforce policy and recovery-oriented principles. Streamlining and modernizing these processes represents a high-impact opportunity to reduce workforce entry barriers, accelerate hiring, and support equitable access to peer roles without compromising public safety. Addressing these barriers directly supports state goals related to workforce expansion, accessibility, and the stabilization of lived-experience roles.

Findings also reinforce the importance of standardized training and supervision as core workforce infrastructure. Strong endorsement of the *Floridians in Recovery* curriculum demonstrates the value of consistent, high-quality certification processes aligned with evidence-based and recovery-oriented care. Expanding access to advanced training in MAT, risk reduction, and trauma-informed supervision further aligns with state priorities to fully integrate peers into evidence-based treatment pathways.

Retention-focused strategies, particularly those that reduce burnout and create clear opportunities for professional advancement, emerge as essential levers for sustaining the peer workforce. Evidence that peer-led supervision is associated with improved perceptions of organizational support and professional development suggests a promising pathway to strengthen leadership pipelines and promote workforce stability.

Overall, these findings point to actionable policy and practice reforms that advance workforce accessibility across urban, suburban, and rural regions, strengthen peer integration across service settings, and support long-term sustainability of the behavioral health peer workforce. By addressing compensation, role clarity, training, supervision, and procedural barriers in a coordinated manner, state and organizational leaders can maximize the effectiveness and impact of peer specialists as a critical

component of Florida's behavioral health system.

## Objective 3: Examine peer models across ROSCs and associated funding models within Florida and across U.S. states Integrated Summary

This objective examined peer workforce models and associated funding models within ROSCs workforce integration, utilization, and sustainability. Findings from the literature, state policy review, secondary data analysis, mixed-methods survey, and qualitative interviews were synthesized to identify workforce strengths, gaps, and opportunities within Florida's publicly funded SUD system.

Florida has implemented several peer-embedded, evidence-informed recovery-oriented models, including Hospital and Jail Bridge Programs, CORE Networks, and RCOs, that align with national best practices for workforce integration. These models position CRPS as frontline workforce members supporting care transitions, treatment engagement, and long-term recovery through peer-based services across hospital, justice-involved, and community-based settings, reflecting a strong statewide commitment to expanding the peer workforce. Preliminary analyses of secondary service data did not support the effectiveness of peers embedded in either medical setting or jail/prison as expected; however, caution is urged in drawing definitive conclusions in light of several notable data limitations and the need for additional levels of analysis. As suggested, future analyses that establish temporal order, examine a dose response measured as the number of CRPS required to have a positive effect, and capture the movement of individuals across service settings within an episode of care are essential to answering the question of effectiveness.

Several important program model considerations did emerge from secondary service data analyses, as well as survey findings and qualitative interviews, that should be considered in peer program development and implementation. First, the ability to engage individuals in peer-led recovery support services in community and in recipients' homes has important implications for the intensity and duration of clinical treatment service engagement. Additionally, the flexibility of CRPS to move across multiple service settings, adapting to meet the needs and preferences of a service recipient, also emerged as an apparent advantage for promoting clinical treatment engagement. While not examined specific to RCOs, these findings do lend support to the model and highlight their potential effectiveness in guiding and actively sustaining recipients' engagement in clinical treatment. Lastly, as suggested, program models that center peers in supervisory roles have meaningful implications for strengthening peer workforce support and integration, creating opportunities for advancement, and

ultimately promoting employee retention.

With regards to financial models, nationally, peer recovery support services are financed through a complex blend of federal, state, local, and private funding streams, with grants serving as foundational but time-limited resources. State appropriations, Medicaid, discretionary opioid response grants, and settlement funds supplement federal support, yet reliance on any single source is insufficient for sustainability. Best practices indicate that braided funding supports both billable peer services and essential non-billable functions. While Medicaid offers a critical mechanism for long-term support, utilization is often limited by administrative, reimbursement, and supervision barriers. States that successfully sustain peer services prioritize intentional coordination across funding sources, infrastructure development, and advocacy networks to strengthen service continuity and reduce fragmentation.

In Florida, public funding for peer recovery support follows a braided structure that integrates state general revenue, federal block and discretionary grants, opioid settlement funds, and local investments through the Department of Children and Families and its seven Managing Entities. Substantial allocations have supported workforce development, expansion of Recovery Community Organizations, CORE networks, hospital and jail-based programs, and court diversion initiatives.

Recovery support is formally recognized in Florida administrative code as a nonclinical, peer-delivered service, yet ambiguous supervision requirements create variability in implementation and reimbursement. Medicaid coverage through the Statewide Medicaid Managed Care systems' "In Lieu of Services" provisions provides an additional funding pathway, though underutilization persists due to administrative complexity, eligibility fluctuations, and concerns about preserving the peer service model. Rates are also low relative to other states and administrative costs associated with Medicaid billing may approach or exceed the potential revenue therefore disincentivizing organizational participation.

Data from FY 2022–2025 show recovery support expenditures increased by over 50 percent, reflecting growth in rates and/or service intensity rather than expansion of provider organizations, and highlighting uneven distribution across Managing Entities. Individual and group recovery services accounted for less than one percent of total expenditures, reflecting both persistently low reimbursement rates and limited financial prioritization, despite evidence that peer-delivered services are highly cost-efficient and foundational to recovery systems. Qualitative findings underscore ongoing challenges, including funding uncertainty and inadequate compensation, which threaten workforce sustainability.

Together, national and Florida-specific evidence emphasize that long-term viability of peer recovery services depends on braided, coordinated funding strategies, clear policy frameworks, workforce investment, and infrastructure to support both clinical ancillary and community-based peer functions.

## Limitations and Strengths

### *Secondary Data*

Several data and structural limitations should be considered when interpreting findings from the updated peer and non-peer datasets.

First, the CRPS-only dataset includes service records coded as clinical services, including group therapy/family therapy. This is conceptually inconsistent with established scope-of-practice expectations, as CRPS are not licensed to independently provide psychotherapy or other clinical treatment services. The presence of therapy-coded services within the peer-only dataset introduces ambiguity regarding how services were documented in the source system. It is unclear whether these services were misclassified, whether peers were embedded within clinical encounters but not acting in a therapeutic capacity, or whether clinical services provided by licensed staff were attributed to peer-associated records due to documentation structure. As a result, findings related to services provided within the CRPS-only dataset should be interpreted with caution, as misclassification may affect estimates of clinical service utilization and limit comparability with the non-peer dataset.

Regarding the non-CRPS dataset, it is unclear how the randomized sample of approximately 30 percent of non-CRPS services was obtained. This may introduce unknown biases or confounding factors based on individual demographic and service characteristics compared to the CRPS-only dataset. Additionally, the values for the variables indicating the covered services, specifically recovery support – individual and recovery support – group, were missing, along with the values for which type of treatment was provided during the service event. It is not possible to indicate whether recovery support – individual and/or group was included in the non-CRPS dataset, and the analysis was based on the assumption that all non-CRPS data included exclusively clinical treatment services. Descriptive summary comparison and inferential analysis on the types of treatment provided by CRPS versus non-CRPS was unable to be performed due to said missing data.

In the CRPS versus non-CRPS analyses, clinical treatment engagement was used as an indicator of program effectiveness. Engagement was selected because sustained participation in treatment is widely recognized in behavioral health research and

practice as measure of effectiveness[21-22]. For example, individuals who remain engaged in care for longer periods and attend services more consistently are generally considered more likely to benefit from treatment. However, the available administrative data does not include standardized clinical outcome measures such as symptom reduction, substance use status at follow-up, or long-term recovery indicators, and others. Therefore, the research team relied on measures of service intensity and duration as observable indicators of effectiveness, in addition to successful treatment completion. It is important to note that engagement does not, by itself, confirm clinical improvement or long-term recovery. Rather, it reflects continued involvement in treatment services, which is commonly used in administrative analyses as a proxy for treatment effectiveness when outcome data are limited.

Furthermore, discharge data were provided as a separate standalone dataset that only included completed treatment episodes, with randomized ClientID values that do not correspond to the ClientID's used in the peer and non-peer service datasets. There is no crosswalk or shared unique identifier that would allow linkage across files. Consequently, discharge outcomes cannot be connected to peer-only or non-peer service engagement outcomes at the individual/client level. It also precludes analysis of readmission patterns stratified by peer exposure in the CRPS-only dataset, as it is unclear whether there is service recipient overlap between the CRPS-only and discharge dataset. As a result, the current analyses are limited to comparisons of service utilization patterns, including service intensity and duration, and separately, successful completion of treatment among service recipients with a completed treatment episode.

Finally, as with all administrative datasets, these data were collected for reporting and billing purposes rather than research. Coding practices may vary across providers and settings, and service counts may reflect documentation practices rather than true clinical intensity. Variability in provider documentation may introduce measurement error that cannot be corrected within the constraints of the available data structure.

Taken together, these limitations indicate that conclusions regarding peer involvement should be restricted to observed differences in service utilization patterns. Findings were interpreted within the context of an observational, descriptive secondary data analysis. By avoiding causal claims, the analysis maintains methodological rigor while still offering valuable insights for program monitoring and improvement.

### *Mixed Method Survey*

Several limitations should be considered when interpreting the findings, alongside notable methodological strengths that support the utility of the results for workforce

planning and policy development.

First, the survey relied on a cross-sectional design and self-reported data from peer specialists, while supervisors provided perceptions of peer experiences. As such, findings reflect perceived conditions rather than objective measures and cannot establish causal relationships. However, capturing both peer self-assessments and supervisor perspectives of peers is a key strength of the study, as it identifies perceptual alignment and misalignment across roles. This is an issue of direct relevance to supervision, training, and organizational decision-making.

Second, geographic representation varied across regions, with fewer responses from the Northwest region. However, this distribution mirrors the relatively smaller number of certified recovery peer specialists in those areas and therefore likely reflects underlying workforce availability rather than systematic underrepresentation. Responses were received from a broad range of counties across Florida, including urban, suburban, and rural settings, enhancing the overall geographic relevance of the findings.

Third, workplace setting was categorized into broad groupings. While this approach supported analytic feasibility and interpretability, it may obscure meaningful variation within settings, such as differences in organizational culture, funding structures, or supervisory models. As a result, findings related to work setting should be interpreted as indicative of general patterns rather than precise organizational effects.

Fourth, participation was voluntary, which introduces the possibility of self-selection bias. Individuals who choose to participate may differ from non-respondents in ways that cannot be fully assessed such as engagement with the peer role or organizational climate. For example, the current analyses included 138 CRPS-P or CRPS professionals, though there are over 1,300 CRPS professionals in Florida. Nonetheless, the sample included peers and supervisors across diverse work settings, populations served, and employment contexts, which supports the robustness and practical relevance of the results.

Fifth, some scales, such as peer status and influence and training, demonstrated lower internal consistency than other measures. These constructs were retained because of their strong theoretical relevance to peer workforce integration and because item content reflected core domains emphasized in prior literature and stakeholder input. Given the preliminary nature of this analysis and the expectation that scale performance may improve as additional data are collected, these measures should be interpreted cautiously but remain informative for identifying emerging patterns and areas for further inquiry.

Recruitment for the survey was conducted through DCF-funded programs, consistent with the contractual focus of the evaluation. As a result, the peer specialist sample largely comprised individuals who had already completed the exemption and certification process and were currently employed. Although the survey instrument intentionally included a separate question pathway for peers who were unemployed, including items assessing whether the exemption process contributed to unemployment, only a small number of respondents ($n$ = 4) fell into this category. Due to the limited sample size, these data were excluded from comparative analyses. Accordingly, this limitation reflects a recruitment and scope constraint rather than a survey design weakness. The evaluation necessarily targeted peers working within DCF-funded service contexts, which constrained the ability to systematically capture the perspectives of individuals who may have been denied certification or exited the workforce due to challenges associated with the exemption process. Future research would benefit from targeted outreach strategies, such as snowball sampling or partnerships with peer networks outside funded provider settings, to more fully assess exemption-related barriers among non-certified or unemployed peers.

## *Qualitative Interviews*

Several limitations should be considered when interpreting these findings. The small administrator sample ($n$ = 3) limits the generalizability of system-level perspectives; however, the alignment of their insights with supervisor themes lends support to the credibility of these findings. The predominance of urban participants, 83.8 percent, may underrepresent rural workforce experiences. Additionally, the focus on DCF-funded programs may not reflect the full spectrum of peer services operating across Florida, therefore limiting generalizability. Finally, the cross-sectional design captures a single point in time within an evolving workforce landscape.

Despite these limitations, several methodological strengths enhance confidence in the findings. The sample size ($N$ = 64) provided sufficient depth for thematic saturation across stakeholder groups, with interviews averaging 44.8 minutes, indicating substantial participant engagement. Geographic representation across 33 counties/regions demonstrates broad statewide reach, while the variety of organizational settings, including recovery community organizations, peer-led facilities, hospitals, and integrated behavioral health programs, strengthens transferability to varied practice contexts. The convergence of themes across multiple researcher analyses enhances analytic rigor, while the inclusion of participants with diverse educational backgrounds, GED to master's degrees, and extensive experience ($M$ = 5.0 years) captures perspectives from both emerging and seasoned workforce members. Finally, the focus on DCF-funded programs, while potentially limiting broader

generalizability, provides focused insights into Florida's largest behavioral health funding mechanism, representing the experiences of peers working within the state's primary public behavioral health infrastructure. and increased confidence in observed patterns across peer and supervisor perspectives.

## Next Steps

Over the next few months, the USF evaluation team will conduct community presentations across the state to disseminate findings. These presentations will engage key stakeholders, including peer specialists, RCOs, other service providers, Managing Entities, and policymakers, to discuss implications for peer workforce integration, funding, and sustainability. These sessions will be designed not only to disseminate results, but also to facilitate dialogue around practical application, policy alignment, and workforce development priorities. Feedback gathered during these sessions will be used to refine recommendations, inform implementation strategies, and support the translation of findings into actionable policy, program, and workforce development initiatives. Additionally, the project will promote ongoing learning and improvement by encouraging stakeholders to use evaluation findings to inform continuous quality improvement, workforce planning, and future research. By embedding findings within existing systems, the project supports durable, statewide impact beyond the evaluation period.

# RECOMMENDATIONS

## Objective 4: Data-driven Recommendations to Advance Integration and Promote Sustainability

### *4a. Effective Peer Models*

#### Support a Recovery-Oriented System of Care (ROSC) through integrated data and evaluation.

The Department of Children and Families has begun implementing several evidence-based practices across the state; however, limitations in evaluation across services, systems, and sectors limits the ability to evaluate the effectiveness of Florida programs reliably and in their totality.

DCF should work to strengthen and integrate administrative data systems and implement ongoing evaluation and monitoring to better capture the dynamics of peer service delivery across settings and payment mechanisms, specifically DCF via Managing Entities and AHCA via Managed Medical Assistance plans.

Future evaluation and monitoring efforts should explicitly focus on:

- Access and reach, including population-level penetration of CRPS services and demographic differences in utilization.
- Capturing the full continuum of care across settings and payer, particularly considering braided funding mechanisms to ensure all aspects of the State's complementary inputs and outputs are represented and evaluated as an integrated whole. A Sequential Intercept Model (SIM) procedure is recommended as a first phase approach, with findings guiding a comprehensive, systemic evaluation strategy.

#### Establish procedures to routinely evaluate client-level and population/system-level impacts of recovery peer services.

Sustained evaluation is necessary to inform continuous improvement, guide workforce investments, and strengthen the evidence base for peer-delivered services within Florida's recovery-oriented systems of care.

The following actionable recommendations are suggested:

- Enhance administrative service data reporting to better capture CRPS service provision. Integrate administrative service and clinical or client-level data to support the evaluation of objective individual outcomes associated with the receipt, frequency, duration, and setting of CRPS services.

- Identify targetable client-level and population/system-level metrics attached to service provision. Routinely report at the provider organization, Managing Entity, and statewide service program levels.

    - One example client-level metric is recovery capital, which is embedded in recovery peer service best practices and simultaneously supports system-level evaluation of DCF strategic priorities of service integration, cross-sector coordination at critical points, and recovery sustaining communities. Measuring recovery capital captures not only individual progress but also the accessibility and responsiveness of community resources that support long-term recovery. By incorporating recovery capital into evaluation frameworks, systems can move beyond traditional clinical outcome measures and better capture the relational, social, and structural dimensions of recovery that are central to peer support and to DCF's strategic priorities.

    - Examples of population/system-level metrics include hospitalization rates, overdose-related events, and arrest rates.

- Use evaluation findings to inform training refinements, workforce policies, and future funding, program scale, and sustainability decisions.

### Strengthen peer workforce infrastructure through peer-led supervision.

DCF should promote recovery peer program models that embed experienced CRPS in supervisory and leadership roles. Evidence indicates that peer-led supervision is associated with more favorable organizational and lived-experience climates, stronger perceived support, greater opportunities for advancement and training, and lower intent to leave among peers.

Reducing turnover risk within the peer workforce is essential to continuity of support, integration within service systems, and overall program effectiveness. Peer-led supervision should therefore be considered a core component of effective program model design and implementation.

## *4b. Strategies to Improve Peer Integration across Coordinated Systems and Across Florida*

### Improve cross-system planning through foundational Sequential Intercept Model (SIM) process.

Florida's peer workforce system would benefit from a structured, cross-system planning approach to better understand and strengthen the integration of peer roles across crisis, treatment, and recovery settings. Use of SIM–informed framework could provide a neutral method for examining peer workforce roles, supervision structures, training and certification pathways, and points of system integration, while identifying gaps, redundancies, and opportunities for alignment.

The SIM is a strategic planning process used to examine how individuals, particularly those with mental health and substance use needs, interact with the criminal justice system and where opportunities exist to intervene, divert, or provide support. Developed by the Policy Research Associates, SIM is grounded in the Sequential Intercept Model, which outlines key "intercept points" along the justice continuum where services can be implemented to improve outcomes and reduce system involvement. The SIM brings together cross-system stakeholders, including behavioral health providers, law enforcement, courts, corrections, and community organizations to: (1) map how individuals move through local systems, (2) identify gaps, barriers, and service needs, and (3) develop actionable strategies to improve coordination and outcomes. By focusing on specific points in the system, SIM provides a structured, data-informed way to align services with need, improve system efficiency, and support better individual and community outcomes—especially for those with complex behavioral health challenges.

### Establish a standardized organizational resource to support peer integration.

Peer roles are increasingly embedded across behavioral health, substance use, child welfare, justice-involved, and community-based systems. However, organizations often lack practical guidance on how to distinguish peer support from clinical or case management functions, prepare their workforce for peer integration, and create environments in which peers can succeed. Without shared implementation guidance, peer roles risk role drift, underutilization, or misalignment with core peer values such as mutuality, empowerment, and lived-experience expertise. It is recommended that DCF develop a standardized, practice-informed organizational resource dedicated specifically to peer integration policies and practices, in addition to individual recommendations and requirements referenced in DCF's Recovery Management Practices (DCF Guidance Document #35) resource. This new resource should be disseminated and made publicly available with the goal of providing clear, accessible

guidance for organizations seeking to implement or strengthen peer support functions in ways that align with recovery-oriented values, professional standards, and regulatory requirements. A resource of this type should be designed for broad applicability across provider types and funding streams.

The proposed resource should integrate existing pieces of information across sources, including FADAA; DCF Guidance Documents and related-cited sources, in one centralized document to include guidance on:

- Defining peer roles grounded in lived experience, recovery orientation, and non-clinical support functions.
- Differentiating peer support from traditional service coordination or case management.
- Assessing organizational readiness, including culture, supervision capacity, onboarding practices, and career pathways.
- Recruiting and hiring peers using recovery-affirming practices that value lived experience as expertise.
- Navigating background-screening requirements through individualized, fair, and legally compliant processes.
- Identifying alternatives for incorporating lived experience when direct peer hiring is not immediately feasible.
- Providing peer-specific supervision, professional development, and role protection to promote ethical practice, wellness, and retention.
- Supporting multiple pathways to recovery and honoring unique lived-experience perspectives.

### Enhance organizational practices.

- Organizations employing peers must provide clear role definitions and responsibilities and enforce role boundaries that reflect the unique mutuality of peer-to-client peer work. For example, urine drug screens, treatment planning, and the like are not appropriate peer responsibilities.
- Lower intent to leave among peer specialists supervised by other peers suggest that peer-led supervision meaningfully supports retention. Agencies and systems

should prioritize the development and sustainability of peer-to-peer supervision structures, particularly in settings that rely heavily on certified recovery peer specialists.

- Organizations should invest in pathways that allow experienced peers to advance into supervisory roles, accompanied by role-specific leadership training and organizational authority to support peers effectively. Peer supervisors may offer greater role understanding, shared lived experience, and contextual insight into peer work, which can foster stronger support, validation, and job satisfaction among peer staff.

- All supervisors of peers should complete the required standardized peer supervision training within 30 days of assuming their supervision role, which may help mitigate differences in retention risk and promote more supportive supervision environments for peers across diverse service contexts.

- Qualitative findings revealed significant variation in integration quality, with some peers in traditional healthcare settings experiencing partial or unclear integration. Further, integration quality directly impacted on professional value perception. Peers are essential team members, and their insights and recommendations should be amplified and integrated across teams and settings. Specific recommended actions are as follows:

    - Include peers in all relevant clinical team meetings, case conferences, and treatment planning discussions where client care is coordinated. While peer-specific supervision and support groups are essential, peers should also be integrated into general staff meetings, celebrations, training opportunities, and decision-making processes.

    - Ensure peers have dedicated time to contribute their unique perspective on individual progress, barriers, and recovery support needs.

    - Value peer observations and insights equally with clinical assessments, recognizing that peers often have access to information and relationship dynamics that clinical staff may not observe.

    - Avoid siloing peer positions or creating separate peer-only spaces that inadvertently marginalize peers from broader organizational activities and inherently reduce integration.

    - Monitor integration quality through regular assessment and feedback mechanisms. This may include periodic surveys or focus groups

specifically examining peer integration experiences or tracking participation rates of peers in various organizational activities to identify potential exclusion patterns.

- Amplify peer voices in organizational decision-making, policy development, and program design. Organizations should move peers from having a seat at the table to having a true voice at the table, making them valued partners in conversations and decision-making. Specific actionable recommendations are as follows:
    - Create formal mechanisms for peer input in organizational governance.
    - Establish peer-led workgroups focused on specific areas such as reducing stigma, improving client engagement, or enhancing cultural responsiveness.
    - Support peer leadership development to prepare peers for expanded decision-making roles.
    - Provide training in organizational leadership, strategic planning, policy analysis, and advocacy.
    - Create pathways for peers to advance into program coordination, quality improvement, training, and policy roles within the organization.
- Stigma from medical providers and a lack of awareness about peer roles within upper management and other departments emerged as barriers to professional recognition. To address these challenges:
    - Include a training section within one of the DCF-required Recovery Management Training Modules that is dedicated specifically to educating all staff about peer roles and value, including recognizing lived experience as complementary to clinical approaches. This section should be in addition to the individual pieces of information included throughout the modules.
    - Implement organization-wide orientations that include dedicated modules on the peer workforce, the evidence base for peer support, and the unique contributions of lived experience.
    - Provide education to clinical staff, such as therapists, counselors, nurses, and physicians on how peer support differs from and complements clinical

interventions.

- Create opportunities for peer specialists to present at staff meetings, training sessions, and continuing education events to increase visibility and understanding.
- Incorporate peer workforce content into clinical degree programs including social work, counseling, nursing, and psychology through partnerships with universities and training programs.

## *4c. Strategies to Improve the Peer Workforce Pipeline*

### Expand training opportunities for peers and key stakeholders.

- Standardize and strengthen peer-specific training across settings**.** Peers reported significantly more favorable perceptions of training than supervisors. To support workforce entry and early retention, training should be standardized statewide to ensure consistency in peer role preparation, expectations, and competencies.
    - Training curricula should emphasize role clarity, ethical boundaries, recovery-oriented practice, and system navigation, while remaining flexible enough to accommodate diverse service contexts.
    - Training should include more comprehensive modules on self-care and vicarious trauma prevention. Training should explicitly address boundary setting and self-care strategies to mitigate high emotional expenditure, compassion fatigue, and potential for burnout.
    - Training modules on MOUD, safety-oriented strategies/risk reduction, co-occurring mental health, and crisis intervention should also be addressed in foundational and continuing CRPS education.
    - Floridians in Recovery and/or NAMI curriculums were recommended by study participants.
- Advanced, continuous training promotes occupational self-efficacy and effectiveness. DCF should enhance funding and access to ongoing training and professional development for peers. Pulling resources across organizations and entities into a centralized location, such as the FADAA Learner Management platform contributes to a robust library of Florida-grounded continuing education resources that reflect the variety of populations, in particular, human trafficking and early psychosis and settings such as child welfare, or criminal justice peers are

serving within, while limiting the resource strain on individual organizations.

  - Clearly publish on the FCB website how CE credits can be earned and tracked through FADAA's Learner Management Platform, including a link and brief description.

  - To reduce confusion, the FCB should clearly align and publish the relationship between the 40-hour content-specific education topics including Advocacy and Whole Health, and the four performance domains tested in the certification exam and referenced as a CEU requirement.

  - Routine, annual review of repository trainings would ensure relevance, accuracy and the most up-to-date information is being received.

  - Making CEUs available at a no or low cost for training completed through this central repository supports peers in maintaining high standards of practice and meeting the requirements for certification renewal and thus continued employment and service to the system.

  - Fund and promote more no-cost online and in-person training opportunities across regions of Florida to ensure equitable accessibility. For example, DCF and FCB approved education and training providers could offer regular refresher training that count for CEUs to ensure peers maintain high standards of practice.

  - Costs of obtaining and maintaining certification, as well as the costs associated with the exemption process may be burdensome. Additional funding and a greater number of certification scholarships should be provided. Relatedly, the FCB should consider a scholarship schedule, so funding is awarded year-round and does not disproportionately favor applications submitted earlier in the year.

- Enhance access to ongoing training and professional development for *peer supervisors*. Training focusing on clarifying roles and responsibilities, training and supervisory models such as shadowing, modeling and live observation, promoting continuous feedback, effective supervisor communication strategies, individualized professional development planning, and monitoring for and mitigating risks for burnout and work-life imbalance may be particularly advantageous. Advanced, continuous training can strengthen the supervisory alliance, reduce work-related burnout, and promote professional advancement for peers.

### Create access and remove structural barriers to peer certification.

- Expand structured pathways from certification to employment. High perceived effectiveness and self-efficacy among peers suggest a workforce that is well-prepared but may encounter barriers during hiring and onboarding. Agencies should strengthen formal linkages between certification, placement, and employment, including partnerships between training entities and DCF-funded providers to streamline recruitment, onboarding, and early supervision for newly certified or provisionally certified peers.

- Improve transparency and communication within the exemption from disqualification process. Survey results indicate that both peers and supervisors rated the exemption process below the scale midpoint, which suggests dissatisfaction with the exemption process. Developing plain-language guidance and technical assistance for applicants and employers could improve perceptions of fairness and accessibility without altering statutory requirements.

- Develop and disseminate, cross-posted within DCF and FCB, educational materials to improve process clarity, support education and process navigation, and promote detailed and complete supporting documentation to accompany exemption requests. This should include but not be limited to:

    - A visual diagram of the multi-entry points cross-agency certification and exemption process in Florida to include initiations by FCB and employers as well as partner organizations FBC and AHCA.

    - Clearly highlighted distinction between certification requirements and employment requirements.

    - Background screening applications and selection of “peer” opposed to “employee” application to apply the less restrictive, State-approved peer criteria to background screening determinations opposed to the more stringent Level 2 criteria.

    - Provide additional details pertaining to exemption from disqualification supporting documentation requirements and standards including court records, notarized letters, and recovery/treatment statement. Hypothetical, model examples that demonstrate “clear and convincing evidence” to guide documentation completion would be particularly helpful. This will help ensure adequate and complete information for DCF’s determination, while also protecting applicant privacy and reducing potential traumatic re-experiencing

to the degree possible.

    - Provide ongoing training to address emerging factors that delay or threaten exemption from disqualification and/or certification.

- Contract with a non-State agency to onboard and retain a Certified Recovery Peer Specialist Legal Advocate to support peers in the exemption process, including navigating the complexities of securing court documentation, supporting evidence of rehabilitation, and expediting the exemption process. This position should not be housed within DCF but should be provided by a vendor specifically contracted to provide this service to any agency certifying or employing peers. This cost could be ascribed to the State's Opioid Settlement Fund. Legal Advocates are not attorneys, but they are trained to understand the court and legal system and have been integrated successfully into the court system in other states.

- DCF should consider developing a more robust data tracking system for exemption from disqualification requests. At a minimum, this should support a calculation of request volume, rate of exemptions granted versus denied, categorization and frequency of exemptions granted and denial reasons, appeal request volume, and rate of successful appeals.

    - Developing a standardized approach to data collection, management, and monitoring will ensure internal compliance with determination completion timelines, identify opportunities for continuous process improvement, and support DCF or division resource requests, such as for additional personnel considering increasing numbers of certified recovery peer specialist applications and exemption requests.

    - Allow easy comparison to non-peer professionals to document fairness and consistency in exemption from disqualification determinations.

    - Evaluate statutory or procedural changes including limitation of document requirement for offenses greater than five years prior and limited exemptions, such as facility or population specific allowances.

    - Identify recurring themes in requests and or DCF determinations, supporting the development of internal decision trees or tiered systems to streamline processes for the applicant and DCF, and to inform policy recommendations to the Legislature.

    - Publishing of aggregate exemption from disqualification denial reasons could help reduce common errors amongst applicants, as well as promote process

transparency.

- Adopt a statute and develop a system to support reciprocity between State secretaries as it relates to exemptions granted. For example, if a secretary grants a peer's full exemption in his or her statutory capacity as DCF Secretary, this exemption should automatically extend to AHCA, allowing the peer to be employed at a treatment agency providing Medicaid-eligible services.

- Develop and support an inter-professional, inter-agency advisory council that routinely reviews exemption from disqualification data.

    - Council should have representation of a certified recovery peer specialist, a behavioral health professional currently working in a community-based setting, a ME, the FCB, and DCF's Office of SAMH.

    - Council could stand to identify and monitor recurring themes, make recommendations to enhance and/or streamline exemption from disqualification decision-making, and make policy recommendations to the Legislature. As such, the Council would have impact on the system, opposed to a direct applicant-level impact.

    - While national experts recommend a formal peer certification review board modeled on national best practices, at present, this may have the unintended consequence of processing delays.

- Strive towards alignment of Florida policies and administrative codes with SAMHSA National Model Standards for Peer Support Certification.

    - As an emerging national leader in coordinated opioid and other substance use disorder programming, and with broader efforts to promote mobility through interstate compacts across health professions, Florida should evaluate current policies and procedures in line with national, best practice standards and strategic imperatives, such as addressing SUD morbidity and mortality.

    - Florida has already taken steps in doing so, such as limiting requirements for hard documents for violations older than five years, and more individualized decision making through limited program types such as facility or population). Next best steps might include:

- The designation of a 90-day determination time in State statute and/or administrative code. Adopting the before noted recommendations could help to reduce system burden, streamline the application process, and reallocate personnel and/or time

resources to meet a more accelerated timeline.

- Amendment of the list of disqualification offenses and/or the creation of a more automated, tiered system within statute, with clear guidelines. A tiered list of offenses, for example, automatically disqualifying, temporarily exempted, non-disqualifying) could dictate determination in statute for common charges associated with substance use disorders including prostitution, burglary and drug charges, saving DCF and the Secretary's discretion only for the most complicated of cases.

- Limiting the scope of the requirement for criminal history documentation during the exemption process to a more reasonable time window. This shift acknowledges long-term recovery and reduces the need for applicants to repeatedly recount past experiences that are no longer reflective of their current stability. In addition, arrest reports, certified court dispositions, and completion of sanction documents should only be required for disqualifying offenses as opposed to both disqualifying and non-disqualifying offenses.

    - National best practice guidelines and the majority of U.S. states place the exemption process at the point of employment, rather than at the point of certification. With Florida's July 2025 "Cleared to Care" requirement for health care practitioners to comply with background screening requirement at initial licensure application and license renewal, it is unlikely that policymakers would make this directional shift with certified recovery peer specialists at this time. As such, recommendations pertaining to this specific standard are deferred at this time.

### Create opportunities for professional advancement and career-sustaining, competitive compensation.

- Promote peer advancement and leadership opportunities within the pipeline. Peers supervised by other peers reported more favorable perceptions of organizational climate, peer status, training, and advancement. Establishing intentional pathways for experienced peers to move into supervisory roles can strengthen the workforce pipeline, support retention, and preserve the integrity of peer practice across systems.

- FCBHW, FCB, and DCF Office of SAMH should collaborate with certified recovery peer specialists and recovery-oriented system of care key stakeholders, including Managing Entities, RCOs, AHCA, and others in the development of a career ladder for certified recovery peer specialists, creating opportunities for advancement while ensuring competency standards are established, opportunities are aligned with

organizational need and capacity, and associated with appropriate compensation. This includes, but is not limited to, a CRPS-S credential.

- Conduct a compensation and employment stability analysis across managing entities and provider types to identify disparities by role, employment status, and setting. Use findings to inform recommended salary bands or minimum compensation benchmarks for peer roles funded through state contracts. Align compensation strategies with the state's broader investment goals to reinforce the compensated value and professionalization of peer roles.

## *4d. Sustainable Funding Models*

### Recognize recovery support services as a system capacity investment.

Continue leveraging opioid settlement dollars and federal block grants to build system-wide infrastructure and advance a recovery-oriented system of care, rather than relying primarily on a crisis-response or acute-care model. This includes expanding RCOs and the peer workforce, implementing evidence-based and advanced skills training (including co-occurring conditions and complex life circumstances), establishing career ladders and retention programs, conducting evaluation and replication studies to scale effective practices, and overhauling data systems with robust quality assurance and quality improvement monitoring.

### Increase the share of DCF's spending dedicated to recovery support services.

Despite a greater than 50 percent increase in absolute dollars, recovery support services remain under one percent of total ME expenditure. Growth occurred alongside declining units, suggesting increased costs rather than broad access expansion.

Consider the establishment of a minimum investment benchmark or planning target for recovery support services within ME contracts and/or incentivize MEs to reinvest savings from reduced acute utilization into peer-delivered recovery supports.

### Stabilize and rationalize initiative-Level (OCA) funding to reduce administrative complexity and financial uncertainty and volatility.

Consider consolidating overlapping OCAs supporting recovery services where feasible and consider multi-year initiatives or allowable carryforward provisions for peer services to create more sustainable funding buckets within existing recovery support financing structures.

### Clarify administrative code to distinguish peer recovery services from clinical oversight requirements.

Although Rule 65D-30 recognizes peer recovery services as non-clinical, supervision and documentation expectations for CRPSs are not explicitly differentiated from clinical services. In the absence of clear guidance, interpretation may lean toward oversight requirements as necessitating licensed clinical supervision, creating administrative and financial barriers for peer-led RCOs. DCF should issue clarifying guidance or amend administrative code to specify that peer recovery services delivered by CRPS do not require clinical supervision if services remain within the defined non-clinical peer scope of practice.

### Compel Florida Managed Medicaid Assistance plans to align with departmental peer structures.

Compel Florida Managed Medicaid Assistance plans to align with DCF's structure for peer representation and programming, such as through a Recovery-Oriented Quality Improvement Specialist or a similar administrative role. Promote or incentivize payer-provider partnerships in which payers provide technical assistance and support to promote the adoption of Medicaid billing practices, while peers and provider organizations advise on recommendations and best practices for delivering peer recovery services within a healthcare-payer framework that preserves the essential, non-clinical, and community-responsive elements of the peer model. This will support provider organizations in establishing a more stable funding stream, reducing uncertainty and reliance on short-term funding.

### Establish funding set-asides to support long-term recovery system sustainability.

Mirroring federal block grants such as Substance Abuse Prevention and Treatment Block Grant and Mental Health Block Grant, DCF should consider imposing set-aside benchmarks from time-limited opioid settlement funds and recurring DCF state general fund allocations to build more long-term funding mechanisms and to support the transition to a more cost-effective, risk mitigating, and person-centered recovery-oriented system of care. Parallel benchmarks might include: five percent crisis or acute set-aside; 10 percent recovery support set-aside; 15 to 20 percent prevention.

# Appendix 1 – Literature Review

**Table 1. Literature Review Matrix**

| Author | Year | Title | Methodology | Findings |
|---|---|---|---|---|
| [1]Substance Abuse and Mental Health Service Agency (SAMHSA) | 2025 | Key substance use and mental health indicators in the United States: Results from the 2024 National Survey on Drug Use and Health | Report | Prevalence of adults with a substance use disorder in the U.S. |
| [2]Substance Abuse and Mental Health Service Agency (SAMHSA) | 2025 | 2024 NSDUH detailed tables | Report | Prevalence of specific substance use disorders across adults in the U.S. and their access to treatment |
| [3]Garnett & Miniño | 2024 | Drug overdose deaths in the United States, 2003–2023 | Quantitative | Social and economic impact of the opioid epidemic |
| [4]Florence et al. | 2021 | The economic burden of opioid use disorder and fatal opioid overdose in the United States, 2017 | Quantitative | Negative outcomes associated with opioid epidemic |
| [5]Dolbin-MacNab et al. | 2021 | Grandfamilies and the opioid epidemic: A systemic perspective and future priorities | Review | Impact of opioid epidemic on families |
| [6]Center for Disease Control and Prevention (CDC) | 2025 | U.S. Overdose Deaths Decrease Almost 27percent in 2024 | Web source | U.S. overdose and opioid-related overdose statistics |
| [7]Center for Disease Control and Prevention (CDC) | 2025 | Understanding the Opioid Overdose Epidemic | Web source | Trends in opioid-related overdoses and deaths in the U.S. |
| [8]Mercer et al. | 2021 | Peer support and overdose prevention responses: a systematic 'state-of-the-art' review | Review | Impact of peer workers on opioid overdoses |
| [9]Chhatwal et al. | 2023 | Estimated reductions in opioid overdose deaths with sustainment of public health interventions in 4 US States | Quantitative | Impact of public health interventions on opioid-related overdose deaths |

| | | | | |
|---|---|---|---|---|
| [10]Dowell et al. | 2025 | Why have overdose deaths decreased? Widespread fentanyl saturation and decreased drug use among key drivers | Quantitative | Impact of public health interventions on opioid-related overdose deaths |
| [11]Reinert et al. | 2025 | The State of Mental Health in America 2025 | Report | Past-year substance use disorder prevalence in Florida |
| [12]Substance Abuse and Mental Health Service Administration (SAMHSA) | 2025 | Interactive NSDUH State Estimates | Web source | Past-year substance use disorder prevalence in Florida |
| [13]Florida Department of Law Enforcement | 2025 | Drugs identified in deceased persons by Florida medical examiners 2024 annual report | Report | Trends in overdose deaths and opioid-caused overdose deaths in Florida |
| [14]Huebner et al. | 2018 | Peer mentoring services, opportunities, and outcomes for child welfare families with substance use disorders | Quantitative | Peer specialist employment settings |
| [15]Florida Department of Children and Families | 2016 | Florida Peer Services Handbook | Report | Florida recovery peer specialist model and role |
| [16]SAMHSA | 2012 | SAMHSA's Working Definition of Recovery. 10 Guiding Principles of Recovery | Report | Florida recovery peer specialist model and role |
| [17]International Association of Peer Supporters | 2012 | National Practice Guidelines for Peer Supporters | Report | Florida recovery peer specialist model and role |
| [18]Albright | 2021 | Reaching for their dreams using recovery capital as the foundation for recovery planning | Web source (PowerPoint) | Florida recovery peer specialist model and role |
| [19]Florida Alcohol and Drug Abuse Association | — | Recovery communities | Web source | Role of peer specialists within recovery community organizations |
| [20]Florida Department of Children and Families | — | About CORE Network | Web source | Services provided through the Coordinated Opioid Recovery Network |

| | | | | |
|---|---|---|---|---|
| [21]Mahon et al. | 2025 | Umbrella review of systematic reviews of peer support in substance use settings | Review | Challenges experienced by peer specialists in the workplace |
| [22]Eddie et al. | 2025 | Peer Recovery Support Services and Recovery Coaching for Substance Use Disorder: A Systematic Review | Review | Peer specialist services in treatment settings and their effectiveness |
| [23]Chen et al. | 2023 | Experiences of peer work in drug use service settings: A systematic review of qualitative evidence | Review | Challenges experienced by peer specialists in the workplace |
| [24]Mattick et al. | 2014 | Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence | Quantitative | Effectiveness of medication for opioid use disorder |
| [25]Bell et al. | 2025 | Advancing peer support workforce research: Insights and recommendations through the lens of professionalization | Commentary | Setting-specific gaps in outcomes associated with integration of peer services |
| [26]Eddie et al. | 2019 | Lived experience in new models of care for substance use disorder: a systematic review of peer recovery support services and recovery coaching | Review | Setting-specific gaps in outcomes associated with integration of peer services |
| [27]Wallis et al. | 2023 | Lessons learned from employing Medicaid-funded peer recovery support specialists in residential substance use treatment settings: An exploratory analysis | Qualitative | Organizational and systemic challenges to the integration of peer specialists |
| [28]Wall et al. | 2021 | Experiences and challenges in the role as peer support workers in a Swedish mental health context-an interview study | Qualitative | Challenges experienced by peer specialists in the workplace |
| [29]Kauffman et al. | 2022 | Barriers and Facilitators to Peer Support Services for Patients With Opioid Use Disorder in the Emergency Department | Review | Challenges experienced by peer specialists |

| | | | | |
|---|---|---|---|---|
| [30]Bell et al. | 2025 | Implementation Factors Influencing Peer-Delivered Behavioral Evidence-Based Interventions for Substance Use Disorders: A Scoping Review | Review | Funding mechanisms that support the provision of peer specialist services |
| [31]Lombardi et al. | 2025 | Retaining peers in the behavioral health workforce: Factors associated with peer recovery support specialists intent to remain or leave current position. | Quantitative | Threats to the sustainability of peer specialists |

# Appendix 2 – Descriptives and Statistical Outputs

## Table 1. Characteristics of CRPS-Involved Clinical Treatment Service Events

| | FY 2022-2023 | FY 2023-2024 | FY 2024-2025 | N |
|---|---|---|---|---|
| **Service Characteristics** | n (percent) | n (percent) | n (percent) | Total (percent) |
| Adult Substance Abuse | 160,380 (71.2) | 113,392 (73.1) | 68,454 (75.8) | 342,226 (72.7) |
| Adult Substance Abuse/MH | 64,834 (28.8) | 41,664 (26.9) | 21,830 (24.2) | 128,328 (27.3) |
| **Placement** | | | | |
| Outpatient | 218,716 (97.1) | 150,456 (97.0) | 87,000 (96.4) | 456,172 (96.9) |
| Residential | 3,589 (1.6) | 2,628 (1.7) | 1,893 (2.1) | 8,110 (1.7) |
| Inpatient Detox | 2,490 (1.1) | 1,516 (1.0) | 1,139 (1.3) | 5,145 (1.1) |
| CSU/Inpatient | 360 (0.2) | 454 (0.3) | 252 (0.3) | 1,066 (0.2) |
| State Mental Health | 59 (0.0) | 2 (0.0) | 0 (0.0) | 61 (0.0) |
| **Treatment Location** | | | | |
| Provider Premises | 148,085 (65.8) | 97,735 (63.0) | 52,965 (58.7) | 298,785 (63.5) |
| Community Setting | 30,542 (13.6) | 28,621 (18.5) | 19,683 (21.8) | 78,846 (16.8) |
| Recipient's Home | 27,948 (12.4) | 22,866 (14.7) | 13,663 (15.1) | 64,477 (13.7) |
| Juvenile Detention Center | 11,119 (4.9) | 341 (0.2) | 33 (0.0) | 11,493 (2.4) |

| | | | | |
|---|---|---|---|---|
| Assisted Living Facility | 3,054 (1.4) | 943 (0.6) | 860 (1.0) | 4,857 (1.0) |
| Residential Treatment | 1,189 (0.5) | 931 (0.6) | 766 (0.8) | 2,886 (0.6) |
| Acute Care Setting | 561 (0.2) | 1,244 (0.8) | 440 (0.5) | 2,245 (0.5) |
| Jail/Prison | 389 (0.2) | 540 (0.3) | 547 (0.6) | 1,476 (0.3) |
| Court | 713 (0.3) | 561 (0.4) | 369 (0.4) | 1,643 (0.3) |
| DCF Office | 480 (0.2) | 275 (0.2) | 134 (0.1) | 889 (0.2) |
| Other[a] | 1,134 (0.5) | 999 (0.6) | 824 (0.9) | 2,957 (0.6) |
| **Managing Entity** | | | | |
| BBCBC | 11,819 (5.2) | 15,808 (10.2) | 10,040 (11.1) | 37,667 (8.0) |
| BBHC | 30,115 (13.4) | 17,616 (11.4) | 9,700 (10.7) | 57,431 (12.2) |
| CFBHN | 81,418 (36.2) | 64,510 (41.6) | 38,933 (43.1) | 184,861 (39.3) |
| CFCHS | 28,774 (12.8) | 9,728 (6.3) | 3,941 (4.4) | 42,443 (9.0) |
| LSF | 35,772 (15.9) | 24,819 (16.0) | 12,629 (14.0) | 73,220 (15.6) |
| SFBHN | 19,215 (8.5) | 9,386 (6.1) | 6,175 (6.8) | 34,776 (7.4) |
| SEFBHN | 18,101 (8.0) | 13,189 (8.5) | 8,866 (9.8) | 40,156 (8.5) |

*Note.* N = 470,554. [a]Other treatment locations include Adult Family Care Home, County Health Department, Delinquency Commitment Facility, Foster Home, Group Home for Adults, Group Home for Children, Medical Hospital, Nursing Home, School Shelter Facility, State Mental Health Treatment Facility, and Statewide Inpatient Psychiatric Program Facility due to small n in each category across fiscal years. *** BBCBC = Big Bend Community-Based Care dba Northwest Florida Health Network (NWFHN);

SFBHN = South Florida Behavioral Health Network dba Thriving Mind South Florida.
*Source*: FASAMS

## Table 2. Demographic Characteristics Among Individuals with CRPS Involvement

| | FY 2022-2023 | FY 2023-2024 | FY 2024-2025 | |
|---|---|---|---|---|
| Service recipient Characteristics | n (percent) | n (percent) | n (percent) | Total (percent) |
| **Sex** | | | | |
| Male | 4,754 (53.3) | 3,413 (53.7) | 2,929 (55.9) | 11,096 (54.1) |
| Female | 4,173 (46.7) | 2,937 (46.3) | 2,315 (44.1) | 9,425 (45.9) |
| **Age Range** | | | | |
| 18–29 | 1,797 (20.1) | 1,259 (19.8) | 1,025 (19.5) | 4,081 (19.9) |
| 30–39 | 3,517 (39.4) | 2,381 (37.5) | 1,782 (34.0) | 7,680 (37.4) |
| 40–49 | 1,933 (21.7) | 1,407 (22.2) | 1,280 (24.4) | 4,620 (22.5) |
| 50–59 | 1,198 (13.4) | 908 (14.3) | 762 (14.5) | 2,868 (14.0) |
| 60–69 | 449 (5.0) | 358 (5.6) | 370 (7.1) | 1,177 (5.7) |
| 70+ | 33 (0.4) | 37 (0.6) | 25 (0.5) | 95 (0.5) |
| **Race** | | | | |
| White | 6,662 (74.6) | 4,569 (72.0) | 3,559 (67.9) | 14,790 (72.1) |
| Black | 1,358 (15.2) | 1,148 (18.1) | 1,179 (22.5) | 3,685 (18.0) |
| Multi-Racial | 380 (4.3) | 165 (2.6) | 117 (2.2) | 662 (3.2) |
| Other[a] | 527 (5.9) | 468 (7.4) | 389 (7.4) | 1,384 (6.7) |
| **Ethnicity** | | | | |
| Other Hispanic[b] | 622 (7.0) | 448 (7.1) | 356 (6.8) | 1,426 (7.0) |
| Other Latin American[c] | 932 (10.4) | 453 (7.1) | 381 (7.3) | 1,766 (8.6) |

| | | | | |
|---|---|---|---|---|
| None of the Above | 7,336 (82.2) | 5,421 (85.4) | 4,488 (85.6) | 17,245 (84.0) |
| **MAT Enrolled** | | | | |
| Yes | 1,420 (15.9) | 705 (11.1) | 368 (7.0) | 2,493 (12.1) |
| No | 7,507 (84.1) | 5,645 (88.9) | 4,876 (93.0) | 18,028 (87.9) |

*Note.* N=20,521. [a]Other racial categories included Asian, American Indian, Alaskan Native, and Other. [b]Other Hispanic ethnic categories included Other Hispanic and Spanish/Latino. [c]Other Latin American ethnic categories included Hattian, Mexican, Mexican American, and Puerto Rican.
*Source*: FASAMS

## Table 3. Characteristics of non-CRPS-Involved Clinical Treatment Service Events

| | **FY 2022-2023** | **FY 2023-2024** | **FY2024-2025** | **N** |
|---|---|---|---|---|
| **Service Characteristics** | n (percent) | n (percent) | n (percent) | Total (percent) |
| Substance Abuse | 112,201 (79.3) | 119,819 (79.9) | 107,746 (73.2) | 339,766 (77.5) |
| Substance Abuse/MH | 29,310 (20.7) | 30,102 (20.1) | 39,428 (26.8) | 98,840 (22.5) |
| **Placement** | | | | |
| Outpatient | 130,345 (92.1) | 137,989 (92.0) | 135,576 (92.1) | 403,910 (92.1) |
| Residential | 6,641 (4.7) | 7,509 (5.0) | 7,225 (4.9) | 21,375 (4.9) |
| Inpatient Detox | 3,905 (2.8) | 3,902 (2.6) | 3,723 (2.5) | 11,530 (2.6) |
| CSU/Inpatient | 620 (0.4) | 521 (0.3) | 650 (0.4) | 1,791 (0.4) |
| **Treatment Location** | | | | |
| Provider | 99,937 | 104,391 | 102837 | 307,165 |

| | | | | |
|---|---|---|---|---|
| Premises | (70.6) | (69.6) | (69.9) | (70.0) |
| Community Setting | 10,175 (7.2) | 17,801 (11.9) | 19254 (13.1) | 47,230 (10.8) |
| Recipient's Home | 5404 (3.8) | 5,643 (3.8) | 4951 (3.4) | 15,998 (3.6) |
| Juvenile Detention | 4467 (3.2) | 506 (0.3) | 224 (0.2) | 5,197 (1.2) |
| Assisted Living Facility | 12,544 (8.9) | 13,083 (8.7) | 11539 (7.8) | 37,166 (8.5) |
| Residential Treatment | 5,067 (3.6) | 5,227 (3.5) | 4912 (3.3) | 15,206 (3.5) |
| Acute Care Setting | 600 (0.4) | 1,297 (0.9) | 1430 (1.0) | 3,327 (0.8) |
| Jail/Prison | 915 (0.6) | 822 (0.5) | 519 (0.4) | 2,256 (0.5) |
| Court | 283 (0.2) | 120 (0.1) | 193 (0.1) | 596 (0.1) |
| DCF Office | 957 (0.7) | 30 (0.0) | 22 (0.0) | 1,009 (0.2) |
| Shelter Facility | 386 (0.3) | 511 (0.3) | 388 (0.3) | 1,285 (0.3) |
| Nursing Home | 383 (0.3) | 249 (0.2) | 75 (0.1) | 707 (0.2) |
| Inpatient Psychiatric | 313 (0.2) | 75 (0.1) | 678 (0.5) | 1,066 (0.2) |
| State Mental Health | 7 (0.0) | 49 (0.0) | 62 (0.0) | 118 (0.0) |
| Medical Hospital | 5 (0.0) | 16 (0.0) | 28 (0.0) | 49 (0.0) |
| Other[a] | 68 (0.0) | 101 (0.1) | 62 (0.0) | 231 (0.1) |
| | | | | |

| **Managing Entity*** | | | | |
|---|---|---|---|---|
| BBCBC | 22420 (15.8) | 24,954 9 (16.6) | 21,158 (14.4) | 68,532 (15.6) |
| BBHC | 7509 (5.3) | 6,085 (4.1) | 5,957 (4.0) | 19,551 (4.5) |
| CFBHN | 50085 (35.4) | 55,564 (37.1) | 55,780 (37.9) | 161,429 (36.8) |
| CFCBHS | 16001 (11.3) | 19,036 (12.7) | 17,743 (12.1) | 52,780 (12.0) |
| LSF | 26399 (18.7) | 23,683 (15.8) | 27,091 (18.4) | 77,173 (17.6) |
| SFBHN | 8442 (6.0) | 9,080 (6.1) | 11,479 (7.8) | 29,001 (6.6) |
| SEBHN | 10,655 (7.5) | 11,519 (7.7) | 7,966 (5.4) | 30,140 (6.9) |

*Note. N =438,606.* [a]Other treatment locations included: adult family care home, delinquent commitment facility, foster home, group home for adults, group home for children, and school due to small n in each category across fiscal years.* BBCBC = Big Bend Community-Based Care dba Northwest Florida Health Network (NWFHN); SFBHN = South Florida Behavioral Health Network dba Thriving Mind South Florida. *Source*: FASAMS

## Table 4. Demographic Characteristics Among Individuals with non-CRPS Involvement

| | FY 2022-2023 | FY 2023-2024 | FY 2024-2025 | |
|---|---|---|---|---|
| **Service recipient Characteristics** | **n (percent)** | **n (percent)** | **n (percent)** | **Total (percent)** |
| **Sex** | | | | |
| Male | 8,588 (58.5) | 5,726 (62.0) | 5,135 (62.2) | 19,449 (60.4) |
| Female | 6,096 (41.5) | 3,511 (38.0) | 3,119 (37.8) | 12,726 (39.6) |
| **Age Range** | | | | |
| 18-29 | 3,071 (20.9) | 2,137 (23.1) | 1,796 (21.8) | 7,004 (21.8) |
| 30-39 | 5,222 (35.6) | 3,056 (33.1) | 2,639 (32.0) | 10,917 (33.9) |
| 40-49 | 3,303 (22.5) | 2,048 (22.2) | 1,959 (23.7) | 7,310 (22.7) |
| 50-59 | 2,024 (13.8) | 1,269 (13.7) | 1,112 (13.5) | 4,405 (13.7) |
| 60-69 | 942 (6.4) | 627 (6.8) | 636 (7.7) | 2,205 (6.9) |
| 70+ | 122 (0.8) | 100 (1.1) | 112 (1.4) | 334 (1.0) |
| **Race** | | | | |
| White | 10,374 (70.6) | 6,110 (66.1) | 5,344 (64.7) | 21,828 (67.8) |
| Black | 2,558 (17.4) | 1,965 (21.3) | 1,861 (22.5) | 6,384 (19.8) |
| Other[a] | 1,169 (8.0) | 793 (8.6) | 709 (8.6) | 2671 (8.3) |
| Multi-Racial | 583 (4.0) | 369 (4.0) | 340 (4.1) | 1292 (4.0) |
| **Ethnicity** | | | | |
| Other Hispanic[b] | 1,048 (7.1) | 733 (7.9) | 789 (9.6) | 2,570 (8.0) |
| Other Latin American[c] | 1,499 (10.2) | 1,067 (11.6) | 874 (10.6) | 3,440 (10.7) |
| None of the Above | 12,137 (82.7) | 7437 (80.5) | 6,591 (79.9) | 26,165 (81.3) |

| | | | | |
|---|---|---|---|---|
| **MAT Enrolled** | | | | |
| Yes | 1,653 (11.3) | 567 (6.1) | 573 (6.9) | 2,793 (8.7) |
| No | 13,031 (88.7) | 8,670 (93.9) | 7,681 (93.1) | 29,382 (91.3) |

*Note. N=32,175.* [a]Other racial categories included Asian, American Indian, Alaskan Native, and Other. [b]Other Hispanic ethnic categories included Other Hispanic and Spanish/Latino. [c]Other Latin American ethnic categories included Hattian, Mexican, Mexican American, and Puerto Rican.
*Source*: FASAMS

**Table 5. Distribution of Certified Recovery Peer Specialists and Survey Respondents by Primary Work County**

| County | Count of Florida CRPS | Peer Respondents | Supervisor Respondents |
|---|---|---|---|
| Alachua | 23 | 1 | 1 |
| Baker | 0 | 0 | 0 |
| Bay | 32 | 1 | 1 |
| Bradford | 1 | 0 | 0 |
| Brevard | 19 | 2 | 0 |
| Broward | 185 | 24 | 6 |
| Calhoun | 6 | 0 | 0 |
| Charlotte | 9 | 4 | 1 |
| Citrus | 4 | 2 | 1 |
| Clay | 21 | 0 | 0 |
| Collier | 9 | 3 | 2 |
| Columbia | 3 | 0 | 0 |
| DeSoto | 0 | 0 | 0 |
| Dixie | 3 | 0 | 0 |
| Duval | 86 | 23 | 1 |
| Escambia | 10 | 0 | 0 |
| Flagler | 10 | 3 | 2 |
| Franklin | 5 | 0 | 0 |
| Gadsden | 7 | 2 | 0 |

| | | | |
|---|---|---|---|
| Gilchrist | 0 | 0 | 0 |
| Glades | 0 | 0 | 0 |
| Gulf | 0 | 0 | 0 |
| Hamilton | 2 | 0 | 0 |
| Hardee | 0 | 0 | 0 |
| Hendry | 1 | 0 | 0 |
| Hernando | 25 | 3 | 3 |
| Highlands | 3 | 0 | 0 |
| Hillsborough | 56 | 6 | 2 |
| Holmes | 6 | 0 | 0 |
| Indian River | 17 | 0 | 0 |
| Jackson | 6 | 2 | 0 |
| Jefferson | 3 | 0 | 0 |
| Lafayette | 0 | 0 | 0 |
| Lake | 11 | 0 | 0 |
| Lee | 38 | 3 | 1 |
| Leon | 25 | 1 | 0 |

| | | | |
|---|---|---|---|
| Levy | 3 | 0 | 0 |
| Liberty | 2 | 0 | 0 |
| Madison | 4 | 1 | 0 |
| Manatee | 15 | 0 | 0 |
| Marion | 25 | 1 | 0 |

| | | | |
|---|---|---|---|
| Martin | 7 | 0 | 0 |
| Miami-Dade | 95 | 28 | 9 |
| Monroe | 5 | 4 | 0 |
| Nassau | 11 | 0 | 0 |
| Okaloosa | 15 | 2 | 1 |
| Okeechobee | 2 | 1 | 0 |
| Orange | 65 | 3 | 2 |
| Osceola | 11 | 2 | 0 |
| Palm Beach | 102 | 7 | 3 |
| Pasco | 35 | 2 | 0 |
| Pinellas | 67 | 8 | 7 |
| Polk | 49 | 5 | 1 |
| Putnam | 8 | 0 | 2 |
| St. Johns | 19 | 0 | 0 |
| St. Lucie | 41 | 3 | 1 |
| Santa Rosa | 10 | 0 | 0 |
| Sarasota | 28 | 4 | 3 |
| Seminole | 32 | 2 | 2 |
| Sumter | 0 | 0 | 0 |
| Suwannee | 1 | 0 | 0 |
| Taylor | 1 | 1 | 0 |
| Union | 0 | 0 | 0 |
| Volusia | 60 | 7 | 1 |

| | | | |
|---|---|---|---|
| Wakulla | 7 | 0 | 0 |
| Walton | 3 | 0 | 0 |
| Washington | 3 | 0 | 0 |
| **Total** | **1352** | **161** | **53** |

*Note.* CRPS count reflects the total number of Certified Recovery Peer Specialists registered in each Florida county in 2024. Peer respondents and supervisor respondents represent individuals who completed the study survey and reported that county as their primary work location. Totals reflect unique survey respondents. Although the total peer survey sample included 162 respondents, one peer did not identify a primary work county and is therefore not included in county-level totals (N = 161).
*Source*: Mixed-Method Survey

## Table 6. Mixed-Method Survey Participant Characteristics

| | Peer (N=162) | | Supervisor (N=53) | |
|---|---|---|---|---|
| **Characteristic** | n | percent | n | percent |
| **Age** | | | | |
| 18-29 | 17 | 10.5 | 5 | 9.4 |
| 30-39 | 45 | 27.8 | 21 | 39.6 |
| 40-49 | 47 | 29.0 | 16 | 30.2 |
| 50-59 | 29 | 17.9 | 5 | 9.4 |
| 60-69 | 20 | 12.3 | 6 | 11.3 |
| 70-79 | 4 | 2.5 | . | . |
| **Race** | | | | |
| Black/African American | 34 | 21.0 | 4 | 7.5 |
| White | 114 | 70.4 | 43 | 81.1 |
| Other | 14 | 8.6 | 6 | 11.3 |
| **Ethnicity** | | | | |
| Hispanic | 30 | 18.5 | 11 | 20.8 |
| Non-Hispanic | 132 | 81.5 | 42 | 79.2 |
| **Gender** | | | | |
| Female | 105 | 64.8 | 37 | 69.8 |
| Male | 57 | 35.2 | 15 | 28.3 |
| **Education** | | | | |
| High School/GED | 38 | 23.5 | 6 | 11.3 |
| Some College | 69 | 42.6 | 9 | 17.0 |

| | | | | |
|---|---|---|---|---|
| 2-Year Degree | 22 | 13.6 | 8 | 15.1 |
| 4-Year Degree | 24 | 14.8 | 8 | 15.1 |
| Master's | 8 | 4.9 | 19 | 35.8 |
| Doctorate/Professional Degree | 1 | 0.6 | 3 | 5.7 |

*Source*: Mixed-Methods Survey

## Table 7. Mixed-Methods Survey Participant Employment Characteristics

| | Peer (N=162) | | Supervisor (N=53) | |
|---|---|---|---|---|
| | n | percent | n | percent |
| **Employment** | | | | |
| Full-time | 135 | 83.3 | 51 | 96.2 |
| Part-time | 21 | 13.0 | 1 | 1.9 |
| Contract/per diem | 2 | 1.2 | 1 | 1.9 |
| Volunteer or unpaid role | 3 | 1.9 | . | . |
| Other | 1 | 0.6 | . | . |
| **Certification** | | | | |
| CRPS-P/CRPS | 162 | 100.0 | 28 | 52.8 |
| Not Certified | . | 0.0 | 25 | 47.2 |
| **Endorsement*** | | | | |
| CRPS-Adult | 143 | 88.3 | 27 | 96.4 |
| CRPS-Family | 27 | 16.7 | 9 | 32.1 |
| CRPS-Veteran | 10 | 6.2 | 3 | 10.7 |
| CRPS-Youth | 11 | 6.8 | 4 | 14.3 |
| CRPS-Criminal Justice | 9 | 5.6 | 1 | 3.6 |
| **Salary Range** | | | | |
| Less than $20,000 | 19 | 11.7 | 1 | 1.9 |
| $20,000 - $29,000 | 15 | 9.3 | 1 | 1.9 |
| $30,000 - $39,000 | 39 | 24.1 | 1 | 1.9 |

| | | | | |
|---|---|---|---|---|
| $40,000 - $49,000 | 51 | 31.5 | 11 | 20.8 |
| $50,000 - $59,000 | 26 | 16.0 | 11 | 20.8 |
| $60,000 - $69,000 | 5 | 3.1 | 9 | 17.0 |
| $70,000 or more | 2 | 1.2 | 18 | 34.0 |
| Prefer not to say | 5 | 3.1 | 1 | 1.9 |

*Note*. Percentages for supervisor endorsements were calculated by dividing by 28. CRPS-A: Adult - Lived experience as an adult in recovery for at least two years from a substance use or mental health condition. CRPS-F: Family - Lived experience as a family member or caregiver of someone in recovery from a substance use or mental health condition. CRPS-V: Veteran - Lived experience as a veteran of the armed forces in recovery from a substance use or mental health condition. CRPS-Y: Youth - Aged 18 to 29 with lived experience of a significant challenge between ages 14 to 25 and now living a wellness-oriented lifestyle for at least two years. CRPS-CJ: Criminal Justice - Lived experience involving incarceration, probation/parole, or other criminal justice involvement due to a mental health condition or substance use disorder. *Not mutually exclusive. *Source*: Mixed-Methods Survey

## Table 8. Mixed-Methods Survey Participant Workplace Characteristics

| Peer (N=162) | | | Supervisor (N=53) | |
|---|---|---|---|---|
| | n | percent | n | percent |
| **Primary Work Setting** | | | | |
| Peer-run or consumer-run organization | 38 | 23.5 | 16 | 30.2 |
| Family-run organization | 2 | 1.2 | . | . |
| State, county, or city facility | 8 | 4.9 | 2 | 3.8 |
| Community-based provider or non-profit | 82 | 50.6 | 28 | 52.8 |
| Non-peer agency that also operates some peer-led services | 5 | 3.1 | 1 | 1.9 |
| University (e.g., psychiatry department) | 1 | 0.6 | . | . |
| Veteran's Affairs | 2 | 1.2 | 2 | 3.8 |
| Hospital/Emergency Department | 14 | 8.6 | 1 | 1.9 |
| Other | 10 | 6.2 | 3 | 5.7 |
| **Population Served** | | | | |
| Survivors of trafficking | 44 | 27.2 | 26 | 49.1 |
| Transition-age youth | 36 | 22.2 | 20 | 37.7 |
| Serious mental illness | 71 | 43.8 | 28 | 52.8 |
| Mental health | 132 | 81.5 | 48 | 90.6 |
| Trauma | 91 | 56.2 | 47 | 88.7 |
| Homelessness | 125 | 77.2 | 48 | 90.6 |
| Racial/ethnic minority | 57 | 35.2 | 32 | 60.4 |
| Justice-involved | 90 | 55.6 | 39 | 73.6 |

| | | | | |
|---|---|---|---|---|
| Early psychosis | 36 | 22.2 | 21 | 39.6 |
| Other | 8 | 4.9 | 3 | 5.7 |
| **Primary Work - County Classification** | | | | |
| Urban | 92 | 56.8 | 24 | 45.3 |
| Suburban | 51 | 31.5 | 22 | 41.5 |
| Rural | 19 | 11.7 | 7 | 13.2 |

*Note.* All survey respondents served populations with a substance use disorder. The categories listed reflect additional populations served beyond substance use. Survey respondents were given the option to indicate “Other” for both primary work setting and populations served and to provide a free-text response. Examples of "other” work settings included healthcare systems, insurance providers, homeless shelters, RCOs, problem-solving courts, residential programs, and sheriff’s office/community outreach programs. Examples of “other” populations served included domestic violence survivors, child welfare-involved individuals, first responders, individuals in re-entry, and populations requiring navigation of secondary needs outside of substance use (e.g., mental health, social services). *Source*: Mixed-Methods Survey

## Table 9. Qualitative Interview Participant Characteristics

| | n | **percent** |
|---|---|---|
| **Role Type** | | |
| Peer Recovery Specialist | 42 | 65.6 |
| Peer Supervisor | 19 | 29.7 |
| Administrator | 3 | 4.7 |
| **Gender** | | |
| Female | 48 | 75.0 |
| Male | 16 | 25.0 |
| **Age (Years)** | | |
| Mean (SD) | 44.8 (12.5) | |
| Median | 41.0 | |
| Range | 22-72 | |
| **Race** | | |

| | | |
|---|---|---|
| White | 54 | 84.4 |
| Black/African American | 6 | 9.4 |
| Mixed Race | 3 | 4.7 |
| Native American | 1 | 1.6 |
| **Ethnicity** | | |
| Non-Hispanic | 49 | 76.6 |
| Hispanic | 14 | 21.9 |
| Not specified | 1 | 1.6 |
| **Education Level** | | |
| Some College | 17 | 26.6 |
| Bachelor's Degree | 14 | 21.9 |
| Associate Degree | 11 | 17.2 |
| Master's Degree | 8 | 12.5 |
| GED | 7 | 10.9 |
| High School | 5 | 7.8 |
| Trade/Vocational | 2 | 3.1 |
| **Geographic Setting** | | |
| Urban | 58 | 90.6 |
| Rural | 4 | 6.2 |
| Both/Mixed | 2 | 3.1 |
| **Counties/Regions Represented** | | |
| Sarasota-Manatee | 8 | 12.5 |

| | | |
|---|---|---|
| Broward | 7 | 10.9 |
| Volusia | 5 | 7.8 |
| Hillsborough | 4 | 6.2 |
| Sarasota | 4 | 6.2 |
| Lee | 3 | 4.7 |
| Brevard | 2 | 3.1 |
| Duval | 2 | 3.1 |
| Flagler | 2 | 3.1 |
| Orange | 2 | 3.1 |
| Pasco | 2 | 3.1 |
| Alachua | 1 | 1.6 |
| Bay | 1 | 1.6 |
| Broward-Miami Dade | 1 | 1.6 |
| Charlotte | 1 | 1.6 |
| Dade | 1 | 1.6 |
| Dade-Broward | 1 | 1.6 |
| Indian River | 1 | 1.6 |
| Manatee | 1 | 1.6 |
| Manatee-Sarasota | 1 | 1.6 |
| Marion | 1 | 1.6 |
| Marion-Citrus | 1 | 1.6 |

| | | |
|---|---|---|
| Martin-Okeechobee-St Lucie | 1 | 1.6 |
| Monroe | 1 | 1.6 |
| Osceola | 1 | 1.6 |
| Palm Beach | 1 | 1.6 |
| Pinellas | 1 | 1.6 |
| Pinellas-Pasco | 1 | 1.6 |
| Polk | 1 | 1.6 |
| Seminole | 1 | 1.6 |
| St Johns-Flagler | 1 | 1.6 |
| St Lucie | 1 | 1.6 |
| St Lucie-Indian River-Okeechobee-Martin | 1 | 1.6 |
| **Years of Experience in Peer-Related Roles** | | |
| Mean (SD) | 5.0 (5.4) | |
| Median | 3.0 | |
| Range | 0.1-28 | |
| Unknown | 2 | 3.1 |
| **Certified Peer Recovery Specialist Status** | | |
| Yes | 56 | 87.5 |
| In Process | 4 | 6.2 |
| No | 1 | 1.6 |
| Not A Peer | 3 | 4.7 |

*Note. N* = 64. *Source*: Qualitative Interviews

## Table 10. Perceived Effectiveness Across Work Settings

| Primary Work Setting | N | Mean | SD |
|---|---|---|---|
| Peer-led or consumer-led organization | 41 | 4.55 | 0.92 |
| Community-based nonprofit or mixed-model provider | 91 | 4.68 | 0.6 |
| Institutional or public sector setting | 30 | 4.74 | 0.58 |
| Total | 162 | 4.66 | 0.69 |

*Note.* Peer effectiveness was measured using a three-item composite scale rated from 1 - Strongly Disagree to 5 - Strongly Agree, with higher scores indicating greater perceived effectiveness. Analyses include peer responses only. Mean scores are presented for peer respondents by their primary work setting. Workplace settings were grouped into three categories for analysis. Peer-led or consumer-led organizations include peer-run, consumer-run, and family-run organizations. Community-based nonprofit or mixed-model providers include community-based nonprofits, non-peer agencies that operate some peer-led services, universities, and Veteran's Affairs programs delivered in community settings.

Institutional or public sector settings include state, county, or city facilities, hospitals or emergency departments, Veteran's Affairs programs delivered in institutional settings, and other institutional workplaces.
*Source*: Mixed-Methods Survey

## Table 11. Perceived Effectiveness by County Type

| County Type | **N** | **Mean** | **SD** |
|---|---|---|---|
| Urban | 92 | 4.60 | 0.8 |
| Suburban | 51 | 4.75 | 0.54 |
| Rural | 19 | 4.74 | 0.41 |
| Total | 162 | 4.66 | 0.69 |

*Note.* Perceived effectiveness was measured using a three-item composite scale rated from 1 - Strongly Disagree to 5 - Strongly Agree, with higher scores indicating greater perceived effectiveness. Analyses include peer responses only. Mean scores are presented for peer respondents by their primary work county type.
*Source*: Mixed-Methods Survey

## Table 12. Perceived Effectiveness by Supervisor Type

| Supervisor Type | N | Mean | SD |
|---|---|---|---|
| Non-peer | 65 | 4.76 | 0.46 |
| Peer | 97 | 4.59 | 0.81 |

*Note.* Mean scores are presented for peers who had a supervisor who was or was not a peer specialist. Perceived effectiveness was measured using a three-item composite scale rated from 1 - Strongly Disagree to 5 - Strongly Agree, with higher scores indicating greater perceived effectiveness. Analyses included peer responses only.

*Source*: Mixed-Methods Survey

## Table 13. Intent to Leave by Work Setting

| **Primary Work Setting** | ***N*** | **Mean** | **SD** |
|---|---|---|---|
| Peer-led or consumer-led organization | 41 | 1.88 | 0.96 |
| Community-based nonprofit or mixed-model provider | 91 | 1.78 | 0.96 |
| Institutional or public sector setting | 30 | 2.09 | 0.98 |
| **Overall peer sample** | 162 | 1.86 | 0.96 |

*Note.* Intent to leave was measured using a three-item scale ranging from 1 - Very unlikely to leave to 5 - Very likely to leave, with higher scores indicating greater intent to leave. Analyses include peer responses only. Mean scores are presented for peer respondents by primary work setting, along with the overall peer sample average.
*Source*: Mixed-Methods Survey

## Table 14. Intent to Leave by County Type

| County Type | N | Mean | SD |
|---|---|---|---|
| Urban | 92 | 1.91 | 0.96 |
| Suburban | 51 | 1.91 | 1.06 |
| Rural | 19 | 1.47 | 0.59 |
| **Overall peer sample** | 162 | 1.86 | 0.96 |

*Note.* Intent to leave was measured using a three-item composite scale ranging from 1 - Very unlikely to leave to 5 - Very likely to leave, with higher scores indicating greater intent to leave. Analyses included peer responses only. Mean scores are presented by county type.
*Source*: Mixed-Methods Survey

## Table 15. Intent to Leave by Annual Income

| Annual Income | N | Mean | SD |
|---|---|---|---|
| <$40,000 | 73 | 1.93 | 0.92 |
| ≥$40,000 | 84 | 1.79 | 1.01 |

*Note.* Intent to leave was measured using a three-item composite scale ranging from 1 - Very unlikely to leave to 5 - Very likely to leave, with higher scores indicating greater intent to leave. Analyses included peer responses only. Mean scores are presented by annual income category (<$40,000 vs. ≥$40,000).
*Source*: Mixed-Methods Survey

## Table 16. Intent to Leave by Supervisor Type

| Supervisor Type | N | Mean | SD |
|---|---|---|---|
| Non-peer | 65 | 2.06 | 1 |
| Peer | 97 | 1.73 | 0.92 |

*Note.* Intent to leave was measured using a three-item composite scale ranging from 1 - Extremely Unlikely to 5 - Extremely Likely, with higher scores indicating greater intent to leave. Analyses included peer responses only. Mean scores are presented by supervisor type.
*Source*: Mixed-Methods Survey

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