Peer Recovery Support Services in New York Opioid Intervention Courts: Essential Elements and Processes for Effective Integration

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THE OPIOID EPIDEMIC has had devastating consequences across the United States, with more than 67,000 Americans dying from drug overdose in 2018 (Hedegaard, Miniño, & Warner, 2020). Heroin, prescription pain relievers, and synthetic opioids like fentanyl have contributed to this growing epidemic. In New York State, there was a 200 percent increase in the number of opioid-related overdose deaths between 2010 and 2017 (New York State Department of Health, 2019). Effectively addressing the epidemic—including preventing opioid use morbidities and mortalities—requires a collaborative and comprehensive approach across systems.

Increasingly, peer recovery support services are being incorporated into programs in a variety of settings as a part of comprehensive efforts to address opioid use disorders. The New York State Office of Court Administration is working to integrate peer support into its Opioid Intervention Courts, as it scales this new model for saving lives. As a part of those efforts, a conceptual framework was developed to assist the courts in successfully conceptualizing, planning, and integrating peers into their work. This article describes the innovation, the framework components, and early lessons learned.

Emergence of New Court Model: The Opioid Intervention Court

Since the late 1980s, treatment courts, problem-solving courts, or specialty courts have developed into a widely used approach to addressing the needs of offenders with substance use disorders (SUDs) and/or mental health issues. By working to resolve the underlying personal issues related to justice involvement, these courts disrupt the cycle of relapse, crime, and reincarceration (Shaffer, 2011; Mitchell et al., 2012). The first—and arguably most well-known—of these courts were drug treatment courts, launched in Dade County; family courts, mental health courts, and veterans courts followed. There are now more than 3,000 such courts in the U.S., serving approximately 120,000 individuals annually (Office of National Drug Control Policy, 2011). In this article, we refer to these courts by the emerging term *treatment and recovery courts* (TRCs), which reflects their overarching purpose.

Opioid intervention courts (OICs) are the newest addition to the TRC contingent. OICs are an opportunity to address the opioid epidemic and prevent overdose deaths by rapidly linking participants to evidence-based treatment, including medication-assisted treatment (MAT) and recovery support services. OICs differ from drug courts in several ways: they are pre-plea; they are voluntary, in that they do not rely on legal leverage; they focus on stabilization and crisis intervention; and they are short-term and time-limited. Drug courts are analogous to a hospital, providing long-term support for court-involved individuals with substance use disorders: OICs are the emergency rooms, offering short-term services to individuals with OUDs to prevent overdoses, reduce other harms, and encourage early steps toward recovery. The country's first OIC was launched in Buffalo, New York, in 2017. Since then, other states have adopted the model, which relies on day-of-arrest intervention, OUD treatment, daily judicial supervision, and wrap-around services. The Center for Court Innovation (2019) described the Buffalo OIC operations:

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

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

The Buffalo OIC has shown some early promise. As a result, the NYS Office of Court Administration (OCA) is developing OICs in every judicial district. The goal is to disperse this new model of collaborative care across the state, prioritizing interventions for offenders at high risk of overdose.

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

According to the Centers for Medicare & Medicaid Services (CMS), peer support services are an evidence-based model of care in which a qualified peer support specialist assists individuals with their recovery from substance use and mental health disorders (CMS, 2007). Research findings to date tentatively speak to the potential impact of PRSS across a number of settings, on outcome measures including reduced substance use and SUD relapse rates, improved relationships with treatment providers and social supports, increased treatment retention, and greater treatment satisfaction (Eddie et al., 2019). Research suggests PRSS in community-based programs may lead to reductions in substance use (Kelley et al., 2017), increased use of detoxification programs and residential SUD treatment (Deering et al., 2011), and reduced rehospitalization rates following treatment (Min et al., 2007). For individuals needing inpatient or outpatient treatment for SUD and co-occurring mental disorders, research into PRSS integrated into other settings suggests they may improve outcomes, including getting individuals to SUD treatment faster following SUD treatment referral (James, Rivera, & Shafer, 2014), reducing substance use (Rowe et al., 2007; O'Connell et al., 2017), increasing SUD and medical treatment adherence (Tracy et al., 2011), reducing the frequency of inpatient readmission (O'Connell et al., 2017), and reducing criminal behavior and recidivism (Rowe et al., 2007). PRSS have also been shown to improve relationships with treatment providers, increase treatment retention, increase satisfaction with the overall treatment experience, and decrease substance use (Bassuk et al., 2016; Reif, Lyman, et al., 2014).

Over the past several years, engagement and employment of peer supporters in TRC programming have grown, partly at the behest of funders, but this is not yet well-researched. Two studies show promise. The first indicates that recovery support groups may help address racial disparities in graduation rates (Gallagher & Wahler, 2018), and the second found that recidivism for court graduates who were matched with peer supporters was reduced by half (Belenko, LaPollo, Gesser, & Peters, 2018; Belenko, LaPollo, Marlowe, Rivera, & Schmonsees, 2019; Belenko et al., 2019).

Adding Peer Recovery Support Services to Treatment and Recovery Courts

In theory, adding PRSS to TRCs is a simple undertaking: Just add peer recovery supporters to the existing multidisciplinary teams composed of judges, prosecutors, defense attorneys, court administrators, behavioral health clinicians, social workers, and other court staff. In practice, it is more complex because of the nature of peer relationships, the variety of roles and tasks that peer workers can have, and the range of possible peer supports.

The term peer identifies a single person with a particular lived experience that positions the person as distinct from others. PRSS programs are grounded in a set of principles that have emerged from the experience of people in long-term recovery. The primary principle is keeping recovery first, for both the peer supporter and the individual seeking support. A second core principle is meeting individuals "where they are." In practice, this means being supportive rather than directive, and focusing on strengths and resiliencies. Other foundational principles relate to the authority and expertise of lived experience, mutuality and reciprocity, relationships built on respect and trust, and self-efficacy and empowerment (White, 2009a; Reif et al., 2014; Eddie et al., 2019).

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

Peer supporters have many different titles and roles, depending on setting and context. In the SUD realm, the most well-known is that of peer recovery coach, but there are others including forensic peer recovery specialist, peer navigator, or crisis interventionist, summarized in Table 1 (next page). The core body of knowledge is the same across the roles, but the focus of the core competencies varies in different contexts.

PRSS are person-centered: Through recovery (goal) planning and resource sharing, a

peer practitioner assists others to build a life in recovery—a process of making healthful choices, creating or recreating a meaningful life, and being of service to family, friends, and community. There are four categories of social support: (1) emotional, (2) instrumental, (3) informational, and (4) affiliational (Cobb, 1976; Salzer, 2002). Under this schema, a wide array of PRSS can be offered. Examples for each category are provided in Table 2.

The multifaceted nature of PRSS leads to their adaptability for a variety of settings. However, successful integration takes careful forethought. NYS OCA approached the Training and Technical Assistance Center for PRSS, funded by BJA to assist new and emerging OICs. Together, we developed a conceptual framework, summarized in Figure 1 (next page), that courts can use to conceptualize, plan, and integrate PRSS successfully.

TABLE 1.
Examples of Peer Recovery Specialist Roles

Title/Role	Key Tasks	Locations
Peer Recovery Coach	Guide and mentor person seeking or in recovery; help identify, remove obstacles and barriers; support connections to the recovery community, other resources useful for building recovery capital.	Recovery community centers, correctional settings, inpatient and outpatient SUD treatment programs, behavioral health clinics, community-based settings, recovery residences.
Forensic Peer Specialist	Support people involved with criminal justice system as mentor, guide, and/or resource connector while incarcerated, on probation or in lieu of probation, or in reentry process.	Jails, prisons, jail diversion programs, drug courts, community-based programs.
Recovery/ Crisis Interventionist	Provide support and guidance to person at early (crisis) intercept point along recovery support continuum, linking person to treatment or other recovery support services as requested.	Hospital emergency rooms, police and fire departments, community-based street outreach or harm reduction programs, crisis centers.
Peer Navigator	Provide support and guidance in accessing appropriate services from complex medical, treatment, and social service systems, including application process for health insurance and other entitlement benefits.	Community-based street outreach or harm reduction programs; community health clinics; public health departments.

TABLE 2.
Types of Peer Recovery Support Services

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

Essential Elements of Peer Recovery Support Services in Treatment and Recovery Courts

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

Certified Peers

With the increasing interest in and expansion of peer supports, peer credentialing emerged in the early 2000s with state-recognized certification programs for mental health peer supporters. Certification standardizes the core body of knowledge and core competencies for the role at entry level; candidates demonstrate their proficiency in meeting the requirements through an examination and/or other competency assessment. In many states, it also provides access to a reliable funding stream, as services provided by certified peers become Medicaid-billable. In the TRC context, it is essential to select and hire certified peers, or partner with an agency that hires them, such as an SUD treatment provider, social service agency, or recovery community organization.

Nationally, peer recovery support specialist is an overarching term that refers to persons with lived experience who are supporting others along their path of recovery. In NYS, *certified peer specialist* is a term that is reserved for mental health peers; SUD peers whose services are Medicaid-reimbursable are called *certified recovery peer advocates* (CRPAs). CRPAs have practice-specific education, profession-specific ethics, and role-specific certification. They "bridge the gap between clinical prevention-treatment providers and relevant multidimensional resources in the community," through "purposeful conversations using role modeling, motivating,

problem solving, and resourcing" (Alcoholism and Substance Abuse Providers of New York State, 2019). In NYS OICs, CRPAs are an integral part of the multidisciplinary opioid court team, providing support to participants during a very challenging time; their roles and tasks are summarized in the boxes in Figure 2.

Pre-court/Early Engagement with Peer Recovery Specialists

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

NYS OICs incorporate CRPAs into the court process as early as possible to engage individuals in a meaningful way. In several NYS courts, the CRPA is the first person that individuals who are considering participation in the OIC speak with. Court administrators stated that having the first engagement be with a peer rather than court staff changes the dynamic. Individuals appear to be more receptive to information received from a peer, because of the peer's lived experience; they perceive the CRPA as helping them to make an autonomous decision to participate in the court programming and treatment.

FIGURE 1.
Conceptual Framework for PRSS Integration

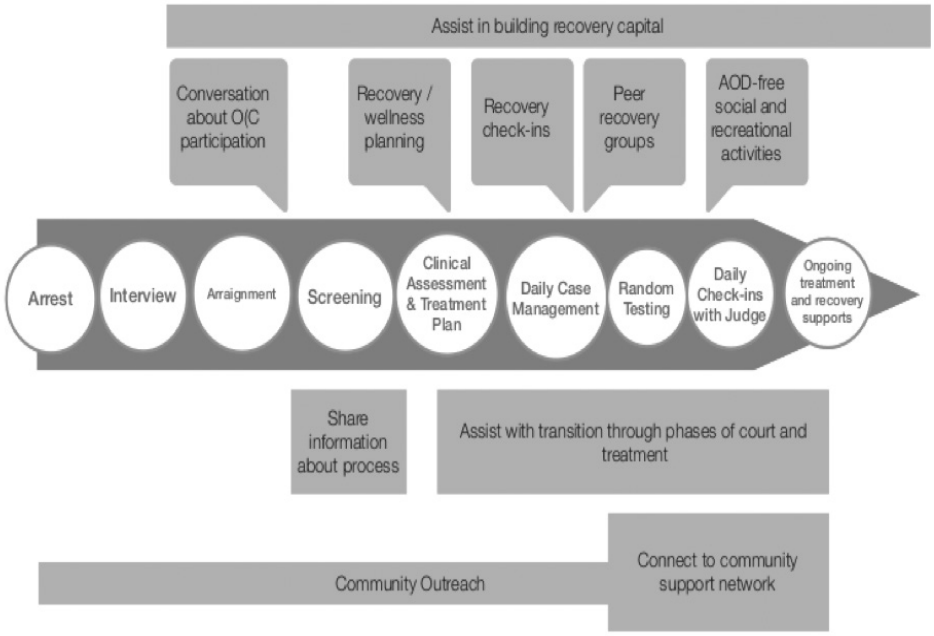
Essential Elements
- Certified peers
- Pre-court/early engagement
- Choice
- Access
- Recovery capital assessment
- Recovery planning and check-ins
- Recovery peer support groups
- Availability of other peer supports
- Linkage to recovery community
- Post-court engagement

Design Factors
- Partner type(s)
- Peerness perspective
- Comprehensiveness, duration, setting(s)
- Geography

Drivers of Success
- Vision
- Alignment
- Engagement
- Selection
- Environment/climate
- Infrastructure and resources
- Ethical framework
- Training and support
- Data and decision-making

Essential Integration Processes
- Prepare to integrate
- Plan appropriate menu of PRSS
- Set policies and procedures
- Launch and refine program
- Schedule regular partner check-ins
- Promote recovery orientation

FIGURE 2.
Opioid Intervention Court Activities and CRPA Tasks



Choice

Choice, self-direction, and empowerment are foundational values of PRSS. These are put into practice in several ways: supporting many pathways to recovery; assuming that the person seeking recovery is fully capable of making informed choices; and respecting an individual's goals, objectives, and preferences (SAMHSA CSAT, 2009). In the general court context, it means that an individual should be able to choose whether to participate in peer supports. Since OICs are voluntary, the choice is whether to engage with the court at all. This re-emphasizes the early role of the peer supporter and points to the need for harm reduction and recovery supports if the individual elects to not pursue OIC.

Access

Peer supports and peer supporters need to be highly and easily accessible to court participants, in terms of location and time of day, so that supports are available when and where needed. There are several strategies for facilitating access: having peer specialists at the court during its hours of operation, offering mobile support, providing access to peers in community-based settings, or offering technology-assisted (phone, text, web-based) peer supports. One respondent noted that a CRPA is available to their OIC participants 24 hours a day for crisis support and to offer recovery supports between traditional service appointments. Another noted that CRPAs can be effective in helping prevent relapse: When a participant shares that he or she feels like using, the CRPA can offer guidance (e.g., strategies for dealing with urges to use) and direct support (e.g., taking the person to a treatment center). Access is also important for peer specialists to effectively do their work. According to respondents, CRPAs gauge the level of contact needed. The barriers they may have in connecting with participants—initially and on an ongoing basis—need to be assessed and addressed within the program design.

Recovery Capital Assessment

Recovery is a journey that involves the growth of recovery capital, which is the sum of the

strengths and supports—both internal and external—that are available to help someone initiate and sustain long-term recovery from addiction (Cloud & Granfield, 2008; White, 2008; Hennessy, 2017). Stable recovery is best predicted on the basis of recovery assets, not pathologies (White & Cloud, 2008; Cano, Best, Edwards, & Lehman, 2017). A recovery capital assessment is a strengths-based tool to measure the strengths, resources, motivation, and aspirations that court participants have that can support them in their recovery journey (Groshkova, Best, & White, 2013). It is also a tool that programs can use to quantify individual-level (Laudet & White, 2008; Sánchez, Sahker, & Arndt, 2020) and program-level recovery outcomes (as opposed to treatment outcomes).

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

Recovery Planning and Recovery Check-ins

A recovery capital assessment is a strengths-based tool to chart growth and change; the recovery plan is a roadmap that takes into account the specific strengths, desires, and motivations of the individual. Recovery planning assists individuals to (a) articulate and visualize the kind of life they would like to have in recovery, (b) outline their personal recovery goals, and (c) develop action steps to achieve their goals related to the essentials for sustained recovery: a safe and affordable place to live; steady employment and job readiness; education and vocational skills; life and recovery skills; health and wellness; sense of belonging and purpose; community and civic engagement; and recovery support networks.

Recovery check-ins improve the likelihood of sustained sobriety and engagement in a recovery program (Scott & Dennis, 2003). They provide an opportunity for participants to reflect on progress toward the goals they set in their recovery plan, talk about challenges and barriers, and identify resources (Braucht, n.d.). The check-in can also serve as a reminder of the next scheduled court, treatment, or social services appointment.

The practice of recovery planning and check-ins will vary, depending on both individual and program factors. For one NYS OIC, there are three built-in meetings (mandatory check-ins): (1) overdose awareness workshop (first month), (2) medication management workshop, and (3) discharge planning workshop. The program also encourages participants to check in with their recovery coach every time that they appear in court. Another has a different schedule: In the initial stages of the engagement, the CRPA works on wellness plans with each participant. They schedule check-ins based upon the goals participants identify they want to achieve. The wellness plan determines the number of check-ins that are necessary. Regardless of site, recovery check-ins are scheduled at regular intervals, more frequently in early recovery and at transition points in recovery, less frequently as time progresses and as participants become more established in their recovery.

Recovery Peer Support Groups

In addition to one-on-one support, peer-facilitated or peer-led groups are another type of resource to help individuals with their recovery. Research has shown that such groups, in combination with other peer services, can increase abstinence, reduce relapse, and increase satisfaction with treatment (Tracy & Wallace, 2016). Groups can be structured or semi-structured, educational or for emotional support, or have mixed components. They can be formed around shared identity, such as belonging to a common cultural group or gender, or shared experience related to building a life in recovery. Group educational activities often focus on a specific subject or skill set, and may involve the participation of a subject matter expert. Peer support groups also offer unique advantages to engaging underserved or difficult-to-engage populations (Rowe et al., 2007; Tracy et al., 2011).

Availability of Other Peer Supports

Working with a peer supporter on recovery capital assessments, recovery planning, and recovery check-ins strengthens desire, motivation, and coping skills for change, all of which are important. So are opportunities to practice new skills in safe and supportive contexts offered by extended classes, workshops, and social and recreational activities (O'Connell et al., 2017; Page & Townsend, 2018; Best et al., 2020). These extended informational and affiliational supports may be difficult to offer within the TRC setting; therefore, partnering to provide access to those resources can support meaningful and lasting change.

Linkage to Broader Recovery Community

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

Post-court Engagement

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

The 10 essential elements of PRSS define a comprehensive model for peer support in TRCs. Not all programs will have all of the elements at their initiation; they are aspirational. Nor do TRCs need to provide these alone; as with other programming, the role of court staff is to ensure that all of the elements are met through effective, strategic partnerships. Last, the elements are flexible, in that there is room for each court to adapt them to reflect local conditions, resources, and constraints.

Essential Processes for Integrating PRSS

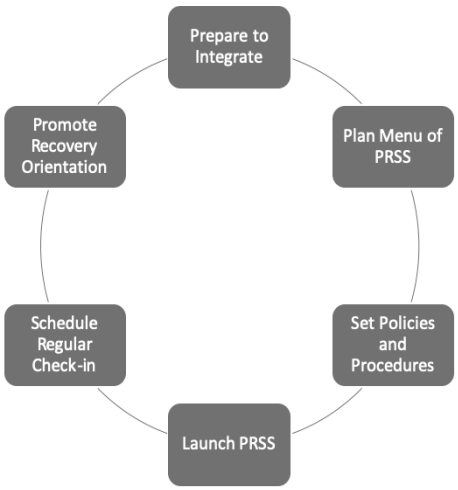
The essential elements offer guidance on what comprises an effective PRSS program; the essential processes describe how to develop such a program. The core processes are shown in Figure 3.

Our thinking on these processes was informed by research related to organizational development, diffusion of innovations (Rogers, 2005), implementation science (Motes & Hess, 2007; Dearing, 2009; Ehrhart, Aarons, & Farahnak, 2014; Weiner, 2020), our experiences with integration of PRSS in other settings, and the practices of the emerging NYS OICs.

Prepare to Integrate Peers into Court Processes

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

FIGURE 3.
Processes for Effective Integration



Plan Appropriate Menu of PRSS

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

The menu should include one-on-one supports (e.g., recovery capital assessment, recovery planning, recovery coaching) and group supports (e.g., classes from which all participants can benefit, groups that further the recovery process, group social activities) and should also include a consideration of where supports will be offered.

Set Policies and Procedures

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

Workflows will also need to be revised. Procedures should describe key tasks and associated tools (e.g., recovery plan, recovery capital assessment), offer approaches to addressing common situations that a peer supporter may encounter, and provide guidelines on when to ask for help from a supervisor or relevant team members. Procedures also need to be in place to monitor and capture information about how well the program is working.

Policies and procedures do not have to be perfect or voluminous. There needs to be enough documentation and detail on paper so that all staff, partners, and participants can be clear and have something to reference.

Schedule Regular Check-ins with Partners

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

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

The early NYS OICs used both informal and formal partner check-ins, which help to (a) inform appropriate resource allocation, (b) identify potential problems and prevent them from escalating, and (c) as necessary, make moderate adjustments or adaptations to work flows and roles of peers. It is an ongoing process of change and adaptation.

These check-ins also serve as a forum to assess early progress and to answer important questions about program operations, including: Are the CRPAs reaching the intended participants? How are other personnel, materials, space, time, and organizational/partner supports contributing to the program? Are the program components being delivered as intended? What have been the challenges or barriers for participants?

Promote Recovery Orientation Among Stakeholders

Recovery is not only an individual, personal transformation process; it happens within systems of care that are recovery-oriented and communities that are recovery-rich. This means that it is important to prepare community partners and stakeholders to do the institution- and community-focused work that will set a context in which personal recovery can happen. The better the understanding of recovery—and the role that PRSS can play in that process—the better the chances for the successful launch and continuation of PRSS in your community. Successful strategies include: hosting meetings that mix treatment

providers, allied professionals, individuals and family members in recovery, and grassroots community organizations; conducting ongoing focus groups, town meetings, and other listening forums; hosting recovery celebration events and recovery conferences; visibly promoting community recovery successes; mapping recovery capital by zip code; conducting recovery prevalence surveys; and establishing recovery-focused performance benchmarks (Evans, Lamb, & White, 2013).

Adapting Peer Supports for NYS Opioid Courts: Early Observations About Design Factors, Drivers of Success, and Situational Factors

The NYS OICs across all 13 judicial districts are relatively new. As noted above, the first began in 2017; others started shortly thereafter, and a few are still in the start-up phase in 2020. We have identified design factors, drivers of success, and unique situational factors that affect their initiation.

Design Factors

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

The second aspect could be called *peerness perspective*. This is related to partnership but also relates to the court's view of the role of the CRPA, whom they serve, and for what purpose. Peer workers can be viewed as an adjunct (i.e., as a junior counselor, junior case manager) who is hired to support and reduce the work of other staff; or as an entry-level supplement to the behavioral health workforce whose job it is to complete routine tasks; or as an autonomous new role focused on participant engagement and progress. These perspectives are neither discrete nor fixed. As the program operations become more established, as the peer role becomes clearer, as peer supporter contributions become more apparent, and as staff and partners assess the program, perspectives may shift. One respondent noted:

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

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

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

Drivers of Success

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

Situational Factors

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

To ensure that courts have the necessary resources, the NYS OCA has developed strategic partnerships with the NYS Office of Addiction Services and Supports (OASAS) and

TABLE 3.
Drivers of Successful Peer Programs

Driver	Summary
Vision	Defining how peer supports will benefit court participants; general role of peer supporters.
Alignment	Ensuring compatible court philosophy, partner philosophies, and core philosophies of peer practice.
Engagement	Fostering deep participation of persons with lived experience in planning and refining program design.
Selection	Recruiting, hiring, and onboarding of individuals who can use lived experience as a tool for inspiring hope, engendering empathy and compassion; finding the right persons for the positions.
Environment/ climate	Organizational context, setting, and culture can have a profound effect on nature and quality of peer support. Creating safe environment in which positive, trusting, peer-to-peer relationships can thrive. More successful when peers meet other places than court—stigma of criminal justice involvement.
Infrastructure and resources	Ensuring infrastructure and resources necessary for effective peer practice (including supervision).
Ethical framework for service delivery	Comprises the certification domain related to ethics, the NY Certification Board Ethical Code of Conduct, the organization-specific ethics guidelines, and the program-specific code of ethics. Regular supervision and check-ins on ethics and boundary issues that arise (e.g., one-on-one problem-solving during supervision; group problem-solving with other CRPAs). Appropriate boundaries (peer-to-peer, and CRPA to court).
Training and support (including supervision)	Building and enhancing competencies of peer supporters, program supervisors, court and partner staff, including an introduction to the criminal justice system; 10 key components of drug courts and best-practice standards; court observation to get familiar with the criminal justice system.
Data and decision- making	Collecting and using data to support and inform; measurements that are recovery- and recovery-capital oriented rather than solely focused on abstinence or recidivism.

the Alcoholism and Substance Abuse Providers of New York State (the State Peer Certification Board). These partners are actively engaged in the OIC initiative, supporting early training and TA for court administrators. OASAS has also provided direct funding to its treatment providers for hiring CRPAs, dedicating a portion of SAMHSA State Opioid Response funds to the effort.

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

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

External Factors. Two significant external factors have slowed program implementation. In 2020, newly enacted reforms to the NYS bail system went into effect; individuals arrested for low-level offenses are now issued a "desk ticket" to appear in court at a future date. This effectively eliminates the initial contact point for OICs—post-arrest detainments at which immediate screening for overdose risk and conversations about the program occurred. OICs have seen significantly decreased participation—and more significantly, are reporting that individuals are returning to the community and overdosing before they can be reached. The COVID-19 epidemic has exacerbated the problem; OICs stopped all in-person appearances—and it is unclear how social distancing will impact future operations.

Both of these external factors lead the OICs to consider how to enhance early contact and engagement strategies—approaches for which peer supporters are uniquely suited—and how PRSS might be expanded with community resources. This requires even more collaboration in an already collaborative model.

Conclusion

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

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

The framework suggests that while the core elements remain the same, PRSS programs will vary from site to site. In that, it parallels peer support itself.

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