SPR SOCIAL POLICY RESEARCH ASSOCIATES
Evaluation, Implementation, Capacity Building

Mathematica®
Progress Together

National Health Emergency Grants to Address the Opioid Crisis:

Implementation Study Final Report

November 24, 2021

Colleen Staatz, Jillian Berk, Crystal Blyler, Katie Bodenlos, Melissa Mack, and Ivette Gutierrez

National Health Emergency Grants to Address the Opioid Crisis:

Implementation Study Final Report

November 24, 2021

Colleen Staatz, Jillian Berk, Crystal Blyler, Katie Bodenlos, Melissa Mack, and Ivette Gutierrez

Submitted to:

U.S. Department of Labor
Chief Evaluation Office
200 Constitution Ave, NW
Washington, DC 20210
Project Officer: Jennifer Daley
Contract Number: 1605DC-18-A-0020\1605DC-18-F-00404

Submitted by:

Mathematica
1100 First Street, NE, 12th Floor
Washington, DC 20002-4221
Phone: (202) 484-9220
Fax: (202) 863-1763

This project was funded by the Chief Evaluation Office of the U.S. Department of Labor under Contract # 1605DC-18-A-0020\1605DC-18-F-00404. The views expressed are those of the authors and should not be attributed to the Federal Government or the Department of Labor.

Acknowledgements

The authors would like to acknowledge the many people who made this evaluation possible and who contributed to this report. Most importantly, the study would not have been possible without the participation of the six NHE demonstration grantees, their subgrantees and partners, and the participants who took time to share their experiences. We received valuable input and guidance throughout the project from Jennifer Daley, our project officer at the U.S. Department of Labor (DOL), Chief Evaluation Office, as well as Charlotte (Sande) Schifferes from DOL's Employment and Training Administration, Office of Policy Development and Research (OPDR). We also appreciated our collaboration with Charlotte Harris, Amy Ambrose, and Ashley Moore in ETA's Office of Workforce Investment, and with Greg Wilson and Cesar Acevedo, also from OPDR.

The evaluation team consisted of many more individuals than those included as authors. Joe Baker, Michaela Vine, Dallas Oberlee, and Kate Dunham participated in both data collection and analysis for this report. Other site visitors included Ben Christensen, Maddy Ruvolo, and Aakash Shah. Patrick Lavallee conducted the statistical programming. The report benefited from careful review by Jeanne Bellotti. Jennifer Brown and Larisa Wiseman provided editorial assistance, Brigitte Tran provided graphics support, and Allison Pinckney and Stephanie Barna provided production support.

This page has been left blank for double-sided copying.

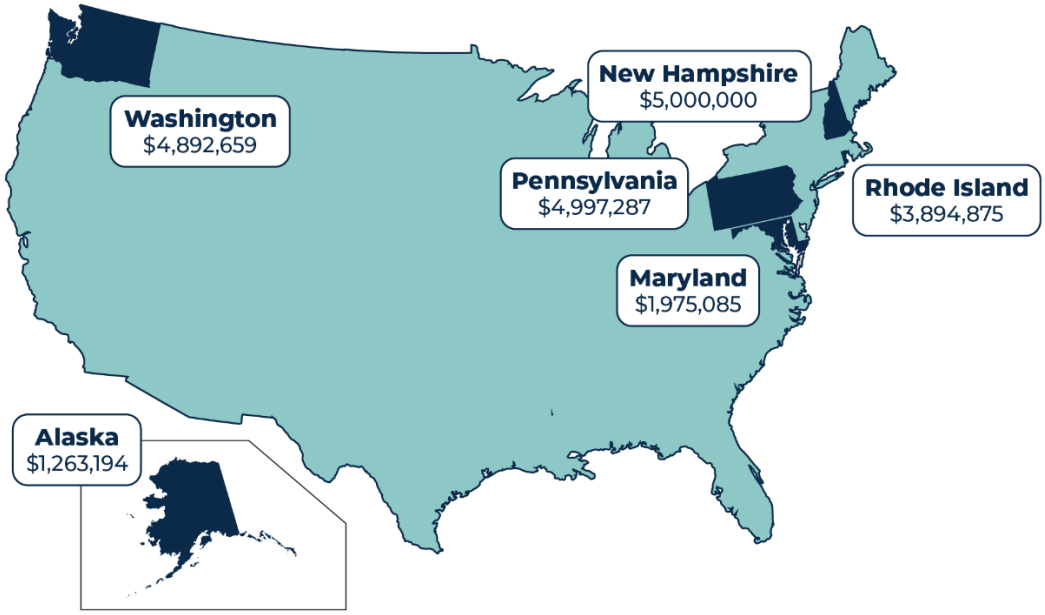
Contents

Exhibits

Executive Summary

In July 2018, the Employment and Training Administration (ETA) of the U.S. Department of Labor (DOL) awarded six grants for demonstration projects to address the opioid crisis through employment and training services. The funds, awarded as National Health Emergency (NHE) Dislocated Worker Demonstration Grants to Address the Opioid Crisis (the NHE demonstration grants), totaled $22 million and were awarded to six state workforce agencies (Exhibit ES.1). The grants encouraged states to test innovative approaches to address the economic and workforce-related impacts of the opioid epidemic. Grantees had wide latitude in how the funds could be used, as long as they fell under one or more of the following categories: services for people affected by opioid addiction, their family members, or others living in communities hard-hit by the opioid crisis; training for workers to address the crisis; and partnerships and system-wide investments to align workforce services with services provided by other organizations in the community.[1]

Exhibit ES.1. NHE demonstration grants and award amounts



In September 2018, DOL contracted with Mathematica[2] to evaluate the implementation of the six NHE demonstration grants. The primary goal of the evaluation was to provide comprehensive information about the implementation of the NHE demonstration grant program, including grantees' partnerships, training and support services provided, target population, common implementation successes and challenges, program outcomes, and plans for sustainability as the grants ended. This report describes the evaluation findings and considers lessons learned and innovative practices for future efforts to provide workforce services and system investments to support people directly and indirectly affected by the opioid crisis.

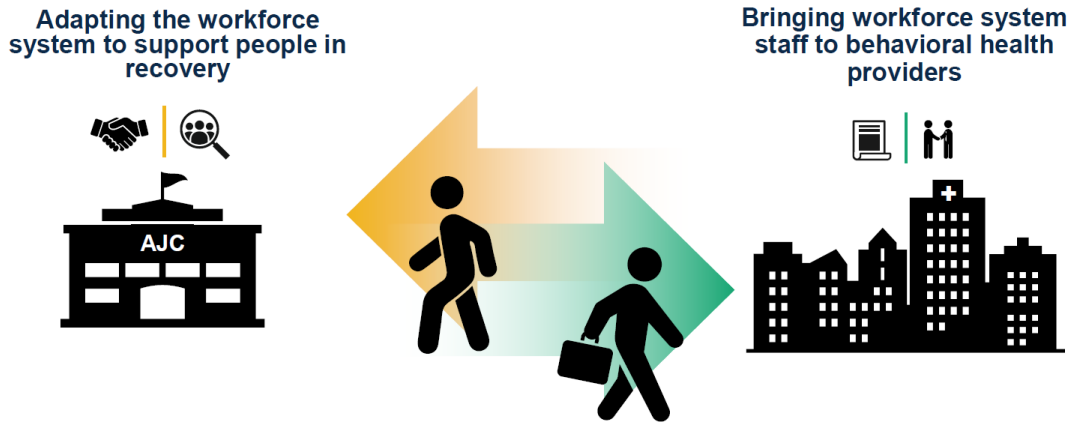
[1] These options were articulated in the Training and Employment Guidance Letter (TEGL) issued to announce the funding availability and to invite applications from states: U.S. Department of Labor. "National Health Emergency Demonstration Grants to Address the Opioid Crisis." Training and Employment Guidance Letter, No. 12-17, March 2018. Available at: https://wdr.doleta.gov/directives/attach/TEGL/TEGL_12-17_Acc.pdf. Accessed June 15, 2021.
[2] Mathematica worked with its subcontractor Social Policy Research Associates to conduct this evaluation.

This report examines the implementation of the six grants and is primarily based on virtual interviews with respondents at both the state level (state grant directors, administrators, and state partner organizations) and the local level (subgrant directors, frontline staff, local partners, and employers). The evaluation team also conducted participant focus groups and analyzed grantee performance data.

The NHE demonstration grant implementation study findings demonstrate potentially promising practices and challenges that grantees faced in implementing these grants.

- **Grantees provided employment services to almost 3,000 participants and made other investments to support individuals in recovery.** All the participants received individualized career services, and 61 percent enrolled in training. Five of the six grantees encouraged participants to consider careers as peer recovery specialists and supported training or paid work experience to assist with certification. Grantees also supported training for incumbent workers to build workforce capacity to serve people with opioid use disorder and worked with employers to promote recovery-friendly workplaces.
- **Partnerships with the behavioral health system were reported as critical for grant implementation.** Since the inception of the NHE demonstration grants, DOL has recognized the importance of partnerships between the workforce and behavioral health systems. Many of the relationships were new, and partners struggled at times to define the purpose of the partnerships. In some cases, behavioral health partners were viewed as sources for mutual referrals or "hosts" for workforce staff. In other cases, partners collaborated to co-create new programs such as a specialized work readiness training for individuals in recovery.
- **The innovative strategies grantees adopted to provide employment and training services generally used one of two models.** In the first model, grantees provided employment services through the existing workforce structure, with some adaptations to better serve this population. The other approach involved bringing workforce system staff on-site to behavioral health facilities to provide services in this setting through partnerships with behavioral health organizations (Exhibit ES.2).

Exhibit ES.2. Grantee approaches to providing employment and training services to people affected by the opioid crisis



AJC = American Job Center.

- **Aligning the expectations of workforce development and behavioral health partners was challenging due to differences in culture and operations**. In particular, the systems had different conceptions of "work readiness." Behavioral health partners expected that anyone who wanted to work would be eligible for American Job Center (AJC) services, but AJCs turned down some potential clients with opioid use disorder whom they deemed not ready to take advantage of their services.
- **Flexible grant eligibility requirements allowed states to take different approaches to participant recruitment, and the approaches were associated with differences in participant characteristics.** Four grantees relied heavily on recruiting participants through behavioral health partner organizations and on-site outreach at treatment facilities and recovery organizations; the other two grantees primarily screened people already seeking AJC services. States with a targeted approach to recruiting participants impacted by the opioid crisis through behavioral health partnerships enrolled more participants with barriers to employment, including prior justice involvement, being homeless at enrollment, having a disability, and not being employed at the time of program entry.
- **Frontline staff and administrators identified the need for intensive case management.** People in recovery recruited through partnerships with behavioral health providers had complex needs and required more support than clients typically served at AJCs. Even when grantees adjusted staffing models to provide more intensive case management than typical in many AJCs, the approaches were still substantially "lighter touch" than those used in the individual placement and support model, which is evidence-based for people with serious mental illness and that researchers are now testing for people with opioid and other substance use disorders (Vine et al. 2020).
- **Efforts to train AJC staff on how to interact with people in recovery appear promising.** Two of the grantees offered training for AJC staff on topics such as substance use disorders, what it means to be in recovery, and how to interact with people with opioid use disorder in a sensitive manner (such as by using person-first language) to help break down stigma around working with people in recovery and improve the experience of people in recovery who seek services at AJCs. Having trainers with lived experience seemed particularly impactful to interview respondents.
- **The workforce system may be able to support a community's recovery infrastructure by helping employers provide recovery-friendly workplaces.** Providing technical assistance to employers through incumbent worker training, recovery-friendly workplace initiatives, and learning communities such as Project Extension for Community Healthcare Outcomes (ECHO) can magnify the workforce system's impact on the outcomes of individuals in recovery.

The NHE demonstration grantees piloted a number of innovative approaches for the workforce systems to help address the effects of the opioid crisis through supporting the employment of people with opioid use disorder, improving the ability of workers in health care and other sectors to respond to the crisis, and helping employers to support employees in recovery. This was a pioneering demonstration that provided states with flexibility to build new partnerships and pursue strategies that responded to local needs. The evaluation highlights potential strategies that state and local workforce areas may want to consider as components of targeted efforts to serve individuals in recovery, as well as broader efforts to ensure that the workforce system and labor market are welcoming to all. However, there is a need for more evidence about the effectiveness of the piloted approaches in increasing employment in people with opioid use disorder.

This page has been left blank for double-sided copying.

I. Introduction

In July 2018, the Employment and Training Administration (ETA) of U.S. Department of Labor (DOL) awarded six grants for demonstration projects to address the opioid crisis through employment and training services. The funds, awarded as National Health Emergency (NHE) Dislocated Worker Demonstration Grants to Address the Opioid Crisis (the NHE demonstration grants), totaled $22 million and were awarded to six state workforce agencies (Alaska, Maryland, New Hampshire, Pennsylvania, Rhode Island, and Washington). The grants encouraged states to test innovative approaches to address the economic and workforce-related impacts of the opioid epidemic. Grantees had wide latitude in how the funds could be used, as long as they fell under one or more of the following categories: services for people affected by opioid addiction, their family members, or others living in communities hard-hit by the opioid crisis; training for workers to address the crisis; and partnerships and system-wide investments to align workforce services with services provided by other organizations in the community. [3]

DOL's Chief Evaluation Office, in collaboration with the ETA's Division of Research and Evaluation, contracted with Mathematica[4] to evaluate the implementation of the NHE demonstration grants. The primary goal of the implementation study is to provide comprehensive information about the implementation of the NHE demonstration grants, including grantees' partnerships, training and support services provided, target population, common implementation successes and challenges, overall outcomes for each grant, and plans for sustainability as the grants ended. This report describes the evaluation findings and considers lessons learned and practices that appear potentially promising for future efforts to provide workforce services and system investments to support people directly and indirectly affected by the opioid crisis.

A. Motivation for the NHE demonstration grants

The opioid crisis has reached an unprecedented level in the United States, with 49,860 people dying from opioid-related drug overdoses in 2019 (Centers for Disease Control and Prevention [CDC] 2021). A recent report by the White House Council of Economic Advisers (2017) found that in 2015, the economic cost of the crisis was $504 billion, or 2.8 percent of gross domestic product that year. The CDC reports that drug overdose deaths have accelerated during the COVID-19 pandemic, with synthetic opioids driving the increase in overdose deaths during the 12-month period ending in May 2020 (CDC 2020).

DOL awarded the NHE demonstration grants because they recognized that the "workforce-related impacts of the opioid crisis may raise new challenges for workforce development agencies" (DOL 2018). The first phase of the evaluation examined what is known about the workforce impacts of the opioid crisis and the potential role of the workforce system to address the crisis (Vine et al. 2020).

The opioid crisis has affected employers across the country. Seventy-five percent of employers feel that their workplace has been impacted by opioid-related issues, but only 17 percent reported feeling extremely well prepared to deal with the opioid crisis (National Safety Council 2019). Employer concerns include difficulty finding qualified workers who can pass drug screens, rising health care costs, increased absenteeism, and reduced productivity. There are additional safety concerns because opioid use can

[3] These options were articulated in the Training and Employment Guidance Letter (TEGL) issued to announce the funding availability and to invite applications from states: U.S. Department of Labor. "National Health Emergency Demonstration Grants to Address the Opioid Crisis." Training and Employment Guidance Letter, No. 12-17, March 2018. Available at: https://wdr.doleta.gov/directives/attach/TEGL/TEGL_12-17_Acc.pdf. Accessed June 15, 2021.
[4] Mathematica worked with its subcontractor Social Policy Research Associates to conduct this evaluation.

contribute to workplace injuries. Highlighting the large economic costs of lost productivity, counties where more opioid pain medication is prescribed have fewer prime-age men and women in the labor force (Krueger 2017). It is difficult to determine whether people are not in the labor force because they are using opioids, or whether not being in the labor force led to misuse of opioids (due to feelings of discouragement or an underlying disability). Regardless of the causality, the lost productivity is clear, particularly for employers.

There is a national shortage of behavioral health providers, who are critical to addressing the opioid crisis. The behavioral health workforce includes substance use treatment providers as well as other behavioral health providers who can provide psychosocial services and counseling and perhaps even help those in recovery keep jobs. Professions with the greatest shortages include psychiatrists and addiction counselors (Health Resources and Services Administration 2020). The workforce system can play an important role in addressing the shortages in behavioral health occupations by directing people into the field, supporting additional training of existing health care workers, and collaborating with partners to increase availability of training. In particular, peer workers are an important and rapidly growing part of the behavioral health workforce that can help address provider shortages (Chapman et al. 2018; Gagne et al. 2018; Johansen 2017). Frontline staff in the workforce system can help to expand the pipeline of peer workers and other behavioral health providers by identifying job seekers who might be appropriate for these roles and providing the referrals and financial support for training.

People with opioid use disorder may need additional support to find and maintain employment. Barriers that people with opioid use disorder may face include periodic relapses that affect their ability to work continuously and perform effectively, which in turn might affect employers' willingness to retain them (Sherba et al. 2018) or hire others who are in recovery. Other challenges might include a drug-related criminal history or felony conviction, loss of their driver's license after driving under the influence, continuing health concerns such as HIV or hepatitis C infection, or probation or treatment program requirements that make it difficult to adhere to work schedules (National Academies of Sciences, Engineering, and Medicine 2019; Sherba et al. 2018). People with substance use disorders might also face stigma and discrimination in the workplace from co-workers or employers (Sherba et al. 2018). Women may be affected by additional challenges to both employment and successful recovery, including employer scheduling practices, low-level positions, and lack of employer supports for managing recovery and other personal responsibilities, such as dependent care (Sinakhone et al. 2017).

Successful employment and recovery from opioid and other substance use disorders are linked in important ways. Employment can be a motivator for entering and adhering to treatment and can result in better treatment outcomes, including completion and duration of treatment, as well as decreases in relapse after treatment (Evans et al. 2010; DeFulio et al. 2012; Everly et al. 2011; Merrick et al. 2012; Petry et al. 2014). Substance use treatment can also help improve work attendance and competency at work (Center for Substance Abuse Treatment 2000).

The local workforce system may not have the capacity or desire to provide services tailored to people with opioid use disorder. Anyone who walks through the door of an American Job Center (real or virtual) is able to access information and job search tools, attend workshops, and receive some light-touch staff assistance as long as they are eligible to work in the United States. Customers with substantial barriers to employment might be offered individualized services that can include an assessment, employment and career counseling, an individual employment plan, assistance to obtain occupational training, and coordination with other service providers. However, provision of individualized services is not automatic as AJCs can exercise flexibility as to whom they enroll based on the resources available

and other priorities (Holcomb et al. 2018). A national evaluation of public workforce services provided under prior law (the Workforce Investment Act) found that most local areas in the study were reluctant to provide individualized services if customers had certain substantial barriers to employment, such as a current substance use problem (D'Amico et al. 2015). Current law (under the Workforce Innovation and Opportunity Act or WIOA) has a stronger focus on increasing access to services for customers with barriers to employment. However, a recent study identified the continuing challenges for local AJCs in serving a greater number of individuals with barriers to employment, due to difficulty in identifying the priority group to which these customers belong, lack of staff expertise in working with them, and lack of capacity to assure that partner programs are able to provide the related services needed by these customers (Dunham et al. 2020).

B. Background on NHE demonstration grants

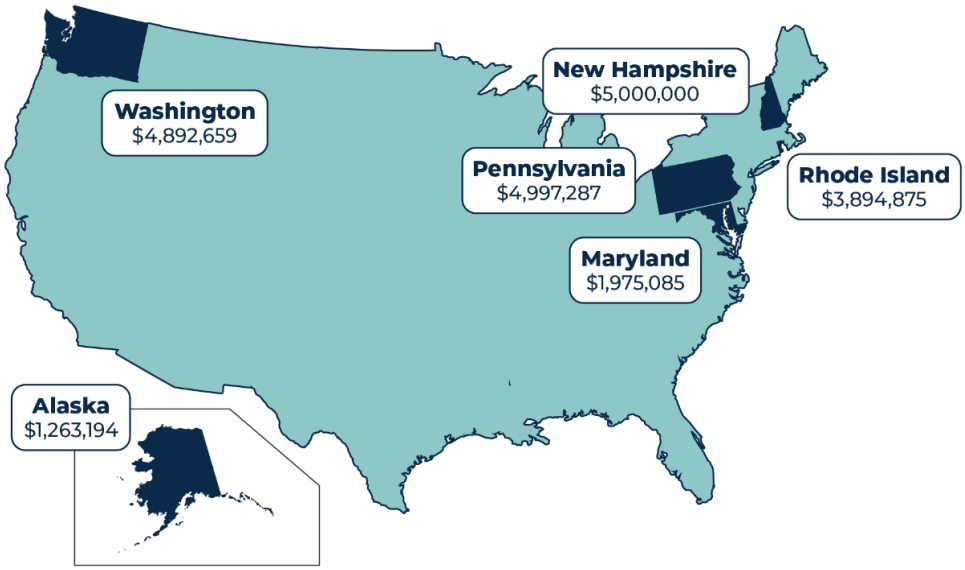
DOL response to the opioid crisis

A March 2018 Training and Employment Guidance Letter (TEGL) announced the availability of funds for grants under the NHE demonstration project and noted that these grants were "DOL's first phase of funding opportunities meant to counter the employment impacts of the opioid crisis and encourage training opportunities for skilled professions positioned to impact the underlying causes of the crisis."[5] Only state workforce agencies could apply and the TEGL encouraged those agencies to consider "innovative approaches" and to "creatively align and deliver career, training, and supportive services to best serve the affected individuals." Grantees were required to identify partners to help in meeting the goals of their projects. Potential partners had to include at least one local workforce development board or American Job Center but also could include employers or industry organizations; community health providers; justice or law enforcement organizations; community-based organizations; and educational institutions.

The NHE demonstration grants were the first phase of a multiyear approach by DOL's Employment and Training Administration (ETA) to administer grant funds to help states combat the economic and workforce impacts associated with the opioid crisis and encourage more people to enter professions that could help address the crisis. These grants were purposefully designed to be exploratory in nature to allow grantees to test different approaches without stringent restrictions on how funding could be used. DOL awarded NHE demonstration grants, ranging in size from $1.3 million to $5 million, to six state workforce agencies in July 2018 (Exhibit I.1). The NHE grants were originally intended as two-year grants scheduled to end in June 2020, but five of the grantees (all except Maryland) requested and were granted one-year, no-cost extensions until June 2021.

[5] U.S. Department of Labor. "National Health Emergency Demonstration Grants to Address the Opioid Crisis." Training and Employment Guidance Letter, No. 12-17, March 2018. Available at https://wdr.doleta.gov/directives/attach/TEGL/TEGL_12-17_Acc.pdf. Accessed June 15, 2021.

Exhibit I.1. NHE demonstration grants and award amounts



Source: https://www.dol.gov/agencies/eta/dislocated-workers/grants/health-emergency/phase-1-demonstration.

As a second phase of ETA's approach to helping communities respond to the opioid crisis, in September 2018, ETA announced the Opioid Disaster Recovery Dislocated Worker grants (Opioid Disaster Recovery grants).[6] These grants aimed to create temporary employment opportunities to alleviate humanitarian and other needs created by the opioid crisis, as well as to provide services to reintegrate workers affected by the crisis and train people to work in mental health treatment, addiction treatment, and pain management. Starting in January 2019, DOL awarded 17 Opioid Disaster Recovery grants, ranging in size from $886,860 to $11 million, to states and tribal organizations.

In addition, the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act; P.L. 115-271), enacted October 24, 2018, directed DOL to carry out a pilot grant program to address the economic and workforce impacts associated with high rates of substance use disorders.[7] Building upon the model established by the NHE demonstration grants and Opioid Disaster Recovery grants, ETA announced the availability of up to $20 million in grant funds for the Support to Communities: Fostering Opioid Recovery through Workforce Development grant program (SUPPORT Act grants). These grants were awarded to four states (Florida, Maryland, Ohio, and Wisconsin) in September 2020. Exhibit I.2 displays the key characteristics of DOL's NHE demonstration grants, Opioid Disaster Recovery grants, and SUPPORT Act grants. This evaluation focuses only on the six NHE demonstration grants. DOL has an ongoing implementation evaluation of the SUPPPORT Act grants.[8]

[6] U.S. Department of Labor. "National Health Emergency Phase Two: Disaster Recovery National Dislocated Worker Grants to Address the Opioid Crisis." Training and Employment Guidance Letter, No. 4-18, September 2018. Available at https://wdr.doleta.gov/directives/attach/TEGL/TEGL_4-18_Acc.pdf. Accessed June 15, 2021.
[7] Available at https://www.congress.gov/bill/115th-congress/house-bill/6. Accessed June 22, 2021.
[8] https://www.dol.gov/agencies/oasp/evaluation/currentstudies/support-to-communities-grant-program-evaluation

Exhibit I.2. DOL's opioid-related grants, 2018-2020

	NHE demonstration grants	Opioid Disaster Recovery grants	SUPPORT Act dislocated worker grants
Number of grants	6	17	4
Grant amounts	$1.3 million to $5 million	$886,860 to $11 million	$4.6 million to $5 million
Grant start date	July 2018	January to December 2019	April to September 2020
Types of eligible participants	• Dislocated workers • New entrants in workforce • Incumbent workers	• Dislocated workers • People temporarily or permanently laid off due to opioid crisis • People who are long-term unemployed • People who have been self-employed but who are currently unemployed or significantly underemployed as a result of the opioid crisis	• Dislocated workers • New entrants in workforce • Incumbent workers • People with barriers to employment
Additional participant eligibility criteria	• People directly or indirectly affected by the opioid crisis • People seeking to enter professions that could help address the opioid crisis and its causes or who need new or upgraded skills to better serve this population	• People directly or indirectly affected by the opioid crisis • People seeking to enter professions that could help address the opioid crisis and its causes • People participating in temporary employment that addresses the unique impacts of the opioid crisis in affected communities	• People directly or indirectly affected by the opioid crisis or another substance use disorder • People seeking to enter professions that could help address the opioid crisis and its causes
Definition of individual directly or indirectly affected by the opioid crisis	• Individual answers yes to the question, "Do you, a friend, or any member of your family have a history of opioid use?" • Individual works or resides in a community hard hit by the opioid crisis or can otherwise demonstrate job loss as a result of the opioid crisis	• Individual answers yes to the question, "Do you, a friend, or any member of your family have a history of opioid use?"	• Individual voluntarily confirms that they themselves, or a friend or family member, have a history of opioid misuse or another substance use disorder
Grant activities	• Provide training and support activities to eligible participants • Provide training that builds the skilled workforce in professions that could impact the causes and treatment of the opioid crisis • Test innovative approaches to address economic and workforce-related impacts of the opioid crisis	• Provide career, training, and support activities to eligible participants • Provide training that builds the skilled workforce in professions that could impact the causes and treatment of the opioid crisis • Create temporary disaster-relief employment that addresses the unique impacts of the opioid crisis in affected communities • Facilitate community partnerships	• Provide training and employment services and comprehensive screening services, including outpatient treatment and recovery care, and other supportive services, to people impacted by the opioid crisis • Engage employers as essential partners • Deliver training and employment opportunities to encourage more people to enter professions that could address the crisis and/or in-demand occupations • Implement innovative approaches to address economic and workforce-related impacts of the opioid crisis

Note: This evaluation only examined the six NHE demonstration grants.

Source: Employment and Training Administration, U.S. Department of Labor. "Grant Types," Available at https://www.dol.gov/agencies/eta/dislocated-workers/grants.

Eligibility criteria for NHE demonstration grants

As shown in Exhibit I.2, the NHE demonstration grants specified that the funding from these grants may be used to serve two populations of workers: (1) workers directly or indirectly affected by the opioid crisis and (2) workers seeking to enter professions that could help address the opioid crisis and its causes. In both of these categories, grant funds could be used to serve dislocated workers, new entrants in the workforce, or incumbent workers (currently employed or underemployed). DOL considered people to be directly or indirectly affected by the opioid crisis if they met one of the following criteria:

- Answered yes to the question, "Do you, a friend, or any member of your family have a history of opioid use?"
- Worked or resided in a community hard hit by the opioid crisis[9] or demonstrated job loss as a result of the opioid crisis, regardless of any personal impact of the crisis on the individual.

The grant program also allowed grantees to train participants seeking to transition to professions that support people with opioid addiction or that could impact underlying causes of opioid addiction, and to train workers already in these professions who need new or upgraded skills to better support people with opioid addiction. Specifically, grantees could provide training to workers in the following professional areas:

- Addiction and substance abuse treatment and related services
- Pain therapy and pain management services that could reduce or prevent dependence on prescription painkillers
- Mental health care treatment services for disorders and issues that could lead to or exacerbate opioid addiction

Summary of strategies NHE demonstration grantees implemented

Grantees implemented a wide range of strategies in their NHE demonstration grants, consistent with the goals of testing innovative approaches to address the economic and workforce-related impacts of the epidemic. Strategies generally fell into the following categories: (1) providing employment services for people directly or indirectly affected by the opioid crisis, (2) supporting people in recovery to become peer recovery specialists[10], (3) training incumbent workers to better address the opioid crisis (primarily health care workers, as well as those in other professions such as law enforcement), and (4) working with employers to create more recovery-friendly workplaces. Although employer-focused strategies were not explicitly mentioned in the TEGL authorizing the grants, three states proposed employer strategies as a key component of addressing the workforce-related impacts of the epidemic. Most states implemented strategies in each of these categories, with some implementing additional activities outside of those categories. Exhibit I.3 displays the major strategies that each grantee implemented through their grant, with icons showing the category corresponding to each strategy. More details about each state's approach are provided in the state profiles in Appendix A of this report.

[9] To demonstrate that communities were hard hit by the opioid crisis, grantees were required to show that the area had an increase equal or greater to the national increase in opioid-related problems between 1999 and 2016. Data that could be used to demonstrate this included rates of opioid abuse, rates of opioid overdose deaths, rates of non-fatal hospitalizations related to opioid abuse, and arrests, convictions, or relevant law-enforcement statistics.

[10] As explained in Chapter IV, peer recovery specialists draw on their personal experiences with substance use disorder treatment and recovery to help others in the recovery process and reduce their likelihood of relapse.

Exhibit I.3. Strategies implemented by NHE demonstration grantee

 Providing employment services for people directly or indirectly affected by the opioid crisis	 Supporting people in recovery to become peer recovery specialists	 Training incumbent workers to better address the opioid crisis (primarily health care workers, as well as those in other professions such as law enforcement)	 Working with employers to create a more recovery-friendly environment

Alaska	
	• Providing services through American Job Centers (AJCs) to people who are eligible for grant-funded services • Providing career exploration camps for youth from families affected by substance use disorders and youth with disabilities
	• Training law enforcement and other employers (small to medium-sized businesses) on helping someone at risk or impacted by opioid use disorder • Training emergency room nurses and staff regarding the opioid crisis and how to avoid staff burnout • Training chemical dependency counselors
Maryland	
	• Providing Opioid Workforce Innovation Funds (OWIF) to 15 subgrantees to provide participants with occupational training and placement and peer recovery specialist certification
	• Providing funding to eight Local Workforce Development Areas to provide general employment and training services, as well as peer recovery specialist certification, for people directly and indirectly affected by the opioid crisis
New Hampshire	
	• Providing employment and training services to people directly or indirectly affected by the opioid crisis
	• Supporting participants to become Certified Recovery Support Workers (CRSWs) through providing work-based job training
	• Providing training and ongoing support for employers on working with people in recovery

Pennsylvania	
	• Providing employment supports to people with opioid use disorder
	• Training Certified Recovery Specialists
	• Training emergency department staff, other health care workers (ambulance services and EMT providers), and human service workers on better serving people with opioid use disorder
	• Engaging employers to support employees in recovery (Project ECHO for employers)
Rhode Island	
	• Connecting job seekers at AJCs from communities highly affected by the opioid crisis with career training/placement and supportive services • Training staff of AJCs and community-based organizations to identify and better serve people with opioid use disorder
	• Providing training and apprenticeships for peer recovery specialists and community health workers
	• Engaging employers to create recovery-friendly workplaces • Providing addiction education for the construction workforce and other affected sectors
Washington	
	• Co-locating workforce services at a “one-stop” center for behavioral health services, employment services, and other services) • Developing transitional jobs for people with opioid use disorder • Using employment navigators to facilitate employment-related services and support services and reach additional communities such as immigrants and refugees • Providing employment services through contracted direct service providers • Offering reentry workshops and work readiness services for people involved in the justice • Expanding the Washington Recovery Helpline (a hotline for recovery services) to the Pac Mountain region • Offering a construction pre-apprenticeship program
	• Training Certified Peer Counselors

Source: Grantee Quarterly Narrative Progress Reports and site visit interviews.

Partnerships

Partnerships were a key focus of the NHE demonstration grants, consistent with the statement in the TEGL that, "A core tenet of the NHE grants is that career and training services are only one part of a comprehensive set of solutions that address the health and well-being of individuals who have been struggling with addiction issues."[11] In their grant applications, grantees were required to identify planned partners with whom they would work to meet their project goals. Required partners included at least one local workforce development board or American Job Center and at least one community organization working with people directly impacted by opioid addiction (such as employers or industry organizations, community health providers, justice or law enforcement organizations, faith- and community-based organizations, or educational institutions). Grantees partnered with all these types of organizations, in addition to others, as shown in Exhibit I.4. These partners played different roles, such referring potential participants to grant services, providing complimentary services to people receiving employment and training services through grant funding, or providing input on grant activities.

Exhibit I.4. Illustrative organizations engaged as partners on NHE grants

State partners	Local partners
• Governor's overdose prevention task forces • State vocational rehabilitation agencies • Other state agencies (including departments of behavioral health care and departments of health)	• Recovery-friendly workplace initiatives • American Job Centers (AJCs) • Behavioral health treatment providers • Recovery community organizations • Hospital and hospital associations • Training providers, including community colleges and community-based organizations (CBOs) • Corrections agencies • CBOs serving as referral partners

Source: Grantee Quarterly Narrative Progress Reports and site visit interviews

C. Effects of the COVID-19 pandemic on grant implementation

Although most of the NHE grants were extended to June 2021 from their original end date of June 2020, many grant activities were disrupted by the COVID-19 pandemic.[12] For example, AJCs and partner community-based organizations (CBOs) had to stop in-person operations, which impacted their ability to provide services. Grantees faced challenges transitioning service delivery to a virtual format, as well as challenges recruiting potential participants. In addition, at least two grantees noted increased barriers to employment for job seekers in recovery, due to more competition in the job market and fear of returning to the workplace because of COVID.

[11] U.S. Department of Labor. "National Health Emergency Demonstration Grants to Address the Opioid Crisis." Training and Employment Guidance Letter, No. 12-17, March 2018. Available at https://wdr.doleta.gov/directives/attach/TEGL/TEGL_12-17_Acc.pdf. Accessed June 15, 2021.
[12] Maryland's grant concluded in March 2020, so this grantee's services were not affected by COVID-19.

D. Research questions

This study focuses on the implementation and context of the NHE demonstration grant in order to identify potentially promising practices and to contribute to the body of evidence on strategies to address the opioid crisis. Key topics explored include partnerships, types of training and support services, target populations, common implementation practices and perceived challenges, general program outcomes, and lessons learned, as related to the overarching research questions for this study. Those questions are as follows:

1. How were the grants implemented, and what factors—including grant context, management, and partnerships—appear to have influenced the implementation?
2. What were the innovative strategies that grantees used to (1) provide employment services for people affected by opioid use disorder, (2) develop the health care workforce that serves people with opioid use disorder, and (3) prevent the negative effects of opioid use disorder in the workplace?
3. What challenges did grantees encounter in implementation, and how were those addressed? What are the lessons learned from the NHE demonstration grants?

This study aimed to generate findings that would be useful to DOL and other stakeholders for informing management decisions, in planning related efforts and grant programs, and for identifying potentially promising approaches to test and refine in the workforce system.

E. Methods and data sources

Our analysis draws on a mix of qualitative and quantitative data from three primary sources that bring together information to address the research questions.

Grantee documentation

We reviewed documentation that grantees submitted to DOL to develop an understanding of their proposed strategies, plans for grant implementation, and how those strategies evolved over time during the grants' period of performance. To develop an initial understanding of the grantees' plans, we reviewed their grant applications and systematically abstracted background information on the state and community context for the grants and about each planned strategy (including target populations, proposed partners, and coordination with other workforce programs).

To obtain information about implementation, we reviewed grantees' Quarterly Narrative Progress Reports (QNPRs), which are prepared by state grant administrators and include a summary of grant progress; descriptions of the implementation of various services; status updates on strategic partnership activities and employer engagement strategies; key issues and technical assistance needs; and substantial activities and accomplishments. We reviewed eight sets of QNPRs for each grantee, from the quarters ending March 31, 2019, through December 31, 2020. We used data from these QNPRs to prepare for virtual site visits and supplement the data collected during the site visits.

Virtual site visits

We conducted virtual site visits with all six NHE demonstration grantees between November 2020 and January 2021. In advance of these site visits, we conducted planning calls with grant leadership in each state. Although the structure of each state grant varied, we conducted interviews with respondents at both the state level (state grant directors, administrators, and state partner organizations) and the local level

(subgrant directors, frontline staff, local partners, and employers). We worked with grant leadership to identify two subgrantees or local areas of each state to participate in our site visit.[13] In states that had more than two subgrantees, we worked with grant leaders to select subgrantees that represented a range of strategies being implemented and diverse geographic regions.

These site visits included semi-structured interviews with 108 respondents at the state and local level, including 10 state grant directors, 5 state administrators, 16 state partners, 21 local subgrant directors, 19 frontline staff, 25 local partners, and 12 employers.[14] In addition, we conducted two 90-minute focus groups in each state with up to five program participants per group, including: (1) participants directly or indirectly affected by the crisis receiving general employment and training services and (2) participants receiving training to become peer specialists or receiving training in other health care occupations to address the opioid crisis (that is, community health workers and nurses). We administered online respondent information forms to all grantee interview respondents and participant focus group members to gather information about demographic characteristics and work histories. Information about interview respondent and focus group participant characteristics is available in Appendix C.

In preparation for the site visits, the evaluation team created customized protocols for each respondent type based on the master protocol. Each customized protocol included a subset of questions most relevant to the respondent's role on the NHE demonstration grant. To the extent possible, we customized the interview protocols based on information already obtained from each grantee through planning calls and review of the grantee's QNPRs.

We had originally planned to conduct site visits with grantees in person but pivoted to virtual site visits due to the COVID-19 pandemic. To mimic the feel of in-person data collection as much as possible, we encouraged participants to use video during the interviews and focus groups. We did not experience challenges recruiting grantee interview participants using the virtual format, but grantees did experience some challenges recruiting program participants to participate in virtual focus groups. As a result, we conducted five individual virtual interviews with program participants who were not able to participate in virtual focus groups at the scheduled times, in order to maximize the number of program participants with whom we spoke. In total, we spoke to 40 participants across focus groups and individual interviews.

Workforce Integrated Performance System (WIPS) data

To supplement our qualitative data collection, we also analyzed Workforce Integrated Performance System (WIPS) data submitted by grantees. The WIPS is a centralized database that contains quarterly data on participants in workforce programs funded by DOL. Grantees submit this participant-level data to DOL on a quarterly basis. We conducted analysis of WIPS data elements, which fall broadly into the following three categories: (1) participant demographics and other characteristics; (2) services provided to participants through the grant, such as basic career services, individualized career services, and training services; and (3) information about educational attainment outcomes, including certificate attainment. One limitation of the WIPS participant data is that we are not able to identify individuals who are in recovery or directly impacted by the opioid crisis. The WIPS does not include indicators of substance use disorders, and grantees were not required to collect this information because of the grant's broad eligibility requirements. Another important limitation is that we were not able to use the individual-level employment and earnings measures included in the WIPS data due to data access restrictions.

[13] Maryland's site visit included three subgrantees to provide a more comprehensive picture, due to the state's unique approach of having a large number of relatively small subgrants (23 total subgrants).
[14] Although there were six states, some states had multiple people serving in director or co-director roles.

We obtained an extract of WIPS data covering the period from July 2018 (i.e., the start of the NHE grants) through March 31, 2021. The extract includes 2,985 participants enrolled across the six grantees. We conducted a descriptive analysis and identified frequencies and means for the full population of participants and the participants in each state. However, we were not able to link participants to specific subgrantees or strategies, and were unable to identify any employment and earnings outcomes for subgrantees or strategies, due to restrictions on access to such outcome data (as noted above).

Limitations

It is important for readers to understand three limitations of this implementation evaluation. First, information from administrators, staff, and participants about implementation quality, successes, and challenges is subjective. To improve our ability to accurately capture these dimensions, the data collection methods included multiple sources of information, including not only grant, subgrant, and partner administrators, but also frontline staff and the participants themselves.

Second, states implemented a wide range of strategies, and our virtual site visits included only two subgrantees or local areas in each state. Therefore, the strategies described in this report should not be viewed as a comprehensive picture of every strategy implemented through the NHE demonstration grants, but rather as an in-depth look at a subset of strategies described by the subgrantees interviewed, along with big-picture information about state practices and perceived challenges obtained from state grant directors and administrators.

Third, the analysis of quantitative data was also limited because we could not identify individuals in recovery, our individual-level data did not include information on labor market outcomes, and we were not able to align the WIPS data with the specific strategies used by grantees and subgrantees discussed in this report.

F. Road map to the report

This report describes grantees' experiences planning and implementing strategies to provide employment services to people affected by the opioid crisis, training workers to address the opioid crisis, and working with employers to implement promising practices to support people in recovery. Integrated throughout the report are examples of practices that appear potentially promising (highlighted in "strategy spotlights"), as well as challenges and potential solutions that grantees shared about each aspect of grant implementation.

The remainder of the report is organized as follows:

- Chapter II describes grantees' approaches to recruiting and enrolling participants directly or indirectly affected by the opioid crisis in order to provide employment services and provides characteristics of participants enrolled in the grant.
- Chapter III outlines grantees' approaches to providing employment services for people directly or indirectly affected by the opioid crisis, including (1) adapting the workforce system to support people in recovery, (2) bringing workforce system staff to behavioral health providers, and (3) developing paths to employment for people in recovery. It also provides details on the types of employment services participants received.
- Chapter IV discusses peer recovery specialist careers, another path to employment available for people in recovery.

- Chapter V outlines grantees' approaches to training incumbent workers to better address the opioid crisis, including opioid-specific training for incumbent health care workers and trainings offered to non-health care workers.
- Chapter VI covers approaches to working with employers to implement promising practices for preventing opioid use disorder and creating a recovery-friendly workplace.
- Chapter VIII presents overall lessons learned and discussion.
- Appendix A presents short profiles of each state grantee.
- Appendix B includes supplemental WIPS tables.
- Appendix C provides more detail on respondent characteristics.

This page has been left blank for double-sided copying.

II. Recruiting and Enrolling Participants

Key findings

- From the start of the grant in July 2018 through March 2021, the six grantees enrolled 2,985 participants.
- Four grantees relied heavily on recruiting participants through referrals from behavioral health partner organizations and on-site outreach at treatment facilities and recovery organizations; the other two grantees primarily screened people already seeking AJC services.
- Grantees noted a wide range of demographic backgrounds among participants receiving employment services through the grant, perhaps reflecting the wide-reaching effects of the opioid epidemic. The administrative WIPS data on participant characteristics confirm this diversity.
- States with a targeted approach to participant recruitment enrolled more participants with barriers to employment including prior justice involvement, being homeless at enrollment, having a disability, and not being employed at the time of program entry.

The majority of services that grantees implemented through the NHE demonstration grants fell under the broad category of providing employment and training services to people directly or indirectly affected by the opioid crisis. From the start of the grant in July 2018 through March 2021, the six grantees enrolled 2,985 participants. This section discusses the criteria used to identify eligible participants directly or indirectly affected by the opioid crisis, as well as the processes grantees used to recruit and enroll participants and the characteristics of participants receiving grant-funded services.

A. Grantee assessment of participant eligibility

Five of the six grantees asked potential participants the eligibility question, "Do you, a friend, or any member of your family have a history of opioid use?" to determine whether they were directly or indirectly affected by the opioid crisis. One state, Rhode Island, considered participants eligible for the grant if they lived in one of the two counties in the state that have been hardest hit by the opioid crisis. At the time of our interviews in November 2020, New Hampshire was also beginning to use zip codes to assess participant eligibility in response to low grant enrollment, with participants living in areas highly affected by the opioid crisis being eligible for grant services.

Grant directors or administrators in three states said they appreciated that they did not have to ask people whether they personally had an opioid use disorder to determine eligibility for grant services. A respondent in Alaska noted that the wording of the self-attestation question helped with the stigma around opioid use, because potential participants did not have to disclose if they had an opioid use disorder or if, instead, someone close to them did. A respondent in New Hampshire concurred, noting that potential participants may not have sought grant services if they were required to disclose whether they had an opioid use disorder. At the same time, grantees noted that people who were in recovery often chose to disclose their recovery status even though doing so was not required for their grant eligibility determination.

Grant administrators also said they appreciated being able to expand eligibility in order to serve "new entrants" to the workforce who would not typically be considered as dislocated workers. For example, state grant leadership in New Hampshire noted that the new entrants comprised the majority of eligible

participants, and that most of the participants referred from recovery centers fell under the new entrant category, since they often had inconsistent work histories of part-time or short-term employment. Expanding eligibility to this group under this grant was helpful, since such participants would not have been eligible for services under other dislocated worker grants.

B. Grantee strategies for recruiting and enrolling participants

Grantee approaches to recruiting and enrolling participants fell into three main categories: (1) referrals from behavioral health partners and other organizations serving people in recovery, (2) on-site outreach and recruitment at recovery organizations and behavioral health treatment facilities, and (3) screening people already seeking AJC services to see whether they would meet grant eligibility criteria.

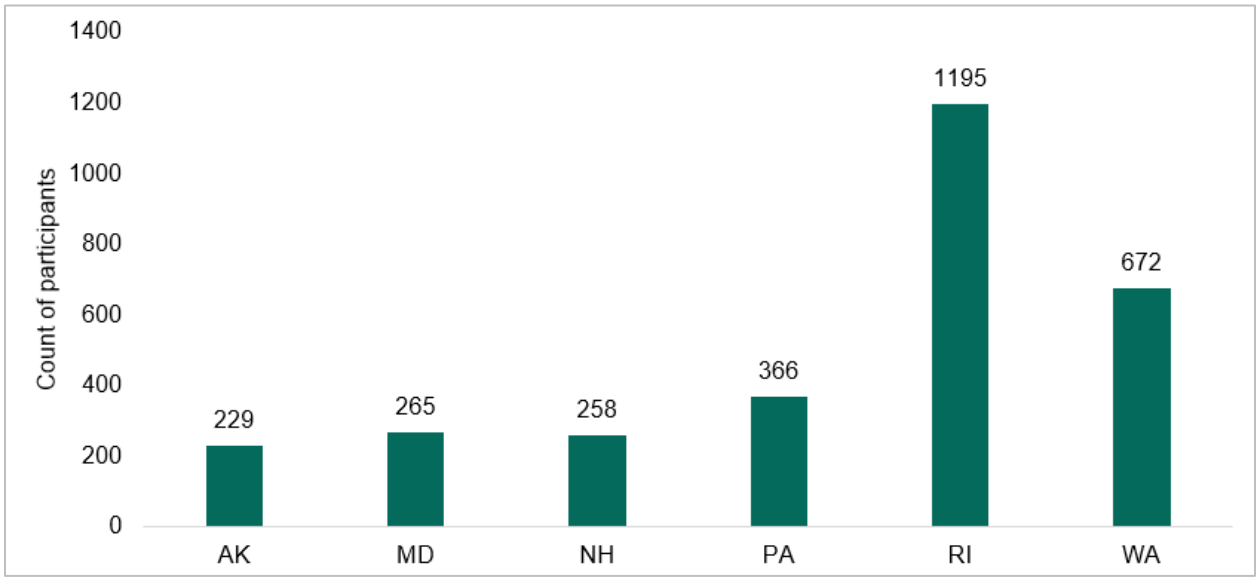
- **Referrals from organizations serving people in recovery**. Grantees that relied heavily on this strategy included Pennsylvania, Washington, New Hampshire, and Maryland. Grantees reported that many of the referral partnerships were reported as newly developed for this grant. New partners included recovery organizations, corrections agencies, homeless shelters, recovery houses, and behavioral health treatment facilities. Grantee staff reached out to these facilities to raise awareness of the services available through the grant and encourage referrals of people who partner organizations thought might be ready for employment and training services to the staff at the AJCs and other agencies providing employment services, such as CBOs. Grantee staff would then formally assess eligibility of those referred. In addition, two grantees noted that once grant services were under way, referrals came by word of mouth. For example, two subgrantees interviewed in Maryland that provided employment services noted that a large portion of their participants were referred by other participants who had received employment and training services through the grant.
- **Outreach and in-person recruitment at recovery organizations and behavioral health treatment facilities.** Pennsylvania, Rhode Island, and New Hampshire hired staff members through the grant—some of whom were in recovery themselves—to conduct outreach, advertise grant services, and recruit participants at recovery organizations. These staff members had strong connections to recovery organizations in their area, such as recovery houses, and they regularly visited these facilities throughout the course of the grant to recruit participants and promote the available employment and training services. They also helped potential participants enroll in grant services. Washington, Pennsylvania, Maryland, and New Hampshire advertised services available through the grant, recruited potential grant participants, and provided workforce services on-site at behavioral health facilities (as described in Section II.C). These hosts of on-site workforce services included a one-stop social service facility providing substance use treatment, an outpatient opioid use disorder treatment facility, a residential treatment facility, and recovery community organizations.
- **Screening people at AJCs**. Alaska and Rhode Island reported that they identified the majority of their grant participants by screening people seeking services at the AJC for grant eligibility. In Alaska, AJC staff asked people seeking services the eligibility question to determine whether they were impacted by the opioid crisis (either directly or indirectly). If they answered yes to the question or they were interested in training in a field that assists with the opioid epidemic (such as health care), they were enrolled under the grant. In Rhode Island, AJC staff did not ask people whether they were affected by the opioid crisis; state grant leadership noted that they were concerned that protecting the confidentiality of this information would be difficult. Instead, the state used zip codes to determine eligibility for the grant, with participants living in zip codes highly affected by the opioid crisis deemed eligible for grant services. Most participants receiving general employment and training

services through the AJCs did not know the grant paid for their services. At the time of our interviews in November 2020, New Hampshire had also begun using zip codes to determine grant eligibility; respondents noted that they adopted this approach to identify additional grant participants due to challenges meeting grant enrollment targets based solely on referrals from behavioral health partners.

C. Enrollment of participants

Over the course of more than 30 months, grantees enrolled 2,985 participants.[15] Participant numbers ranged widely across the states, from 229 participants in Alaska to 1,195 participants in Rhode Island (Exhibit II.1). It is difficult to compare participant enrollment to the initial target because states established enrollment goals for each of their strategies, but not all individuals served under these strategies were counted as grant participants. Multiple factors may have affected these enrollment numbers. The grant amounts varied across the states, with New Hampshire, Pennsylvania, and Washington receiving approximately $5 million each and Rhode Island, Maryland, and Alaska receiving approximately $3.9 million, $2 million and $1.3 million, respectively. Enrollment numbers also reflect the allocation of resources across strategies. The data primarily reflect the number of individuals receiving employment services and occupational training, but they do not reflect participation in other funded activities—such as incumbent worker training and services for employers—where the affected individuals were not counted as participants.[16] Rhode Island's significantly higher number of participants also likely reflects the state's blending of funds across grants and other sources, so NHE demonstration grant funds might only have covered a portion of the services received by enrolled participants.

Exhibit II.1. NHE participant enrollment through March 2021, by state grantee



Source: WIPS data through March 31, 2021.

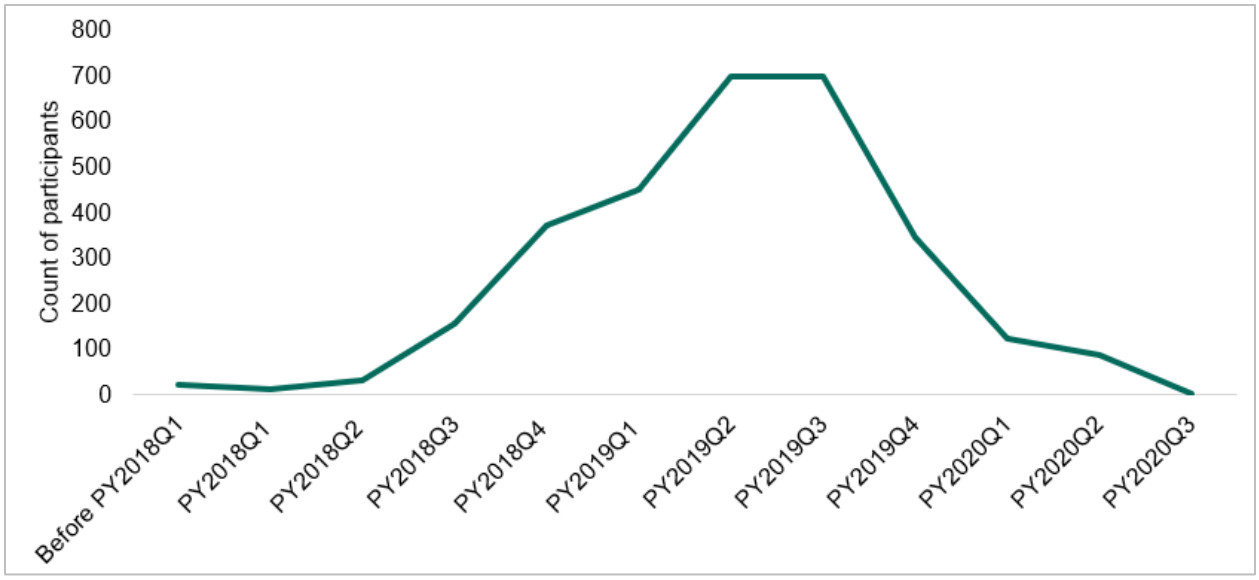
AK = Alaska; MD = Maryland; NH = New Hampshire; PA = Pennsylvania; RI = Rhode Island; WA = Washington.

[15] The WIPS data include participants enrolled through March 31, 2021. Maryland had ended its grant by this point, and the other five states were finishing service delivery.

[16] Unlike other grantees, Pennsylvania attempted to enroll emergency department and human service organization workers trained as part of an incumbent worker training effort (see Chapter V) as participants in the grant.

Enrollment numbers steadily grew as grantees ramped up efforts in 2018, with a peak in mid-2019 before a significant drop in enrollment during the pandemic. Twenty percent of participants enrolled in the first year of the grant. Enrollment was relatively low during that time as grantees hired staff, developed partnerships, and passed funds to subgrantees. After three quarters of increasing enrollment, enrollment started to decline again with the onset of the COVID pandemic in March 2020 (Exhibit II.2). The enrollment decline was especially stark in Washington, which dropped from 106 enrollments in the first quarter of 2020 to 7 enrollments in the second quarter of the year (Appendix Exhibit B.1). This drop in enrollment aligns with challenges (as reported by staff during the site visits) of continuing recruitment and enrollment when partner organizations closed their doors for in-person services. Across grantees, some of the programs attempted to enroll participants virtually once they were able to establish procedures for collecting personally identifiable information, but not all programs were able to pivot.

Exhibit II.2. NHE demonstration grantee enrollment, by program year and quarter



Source: WIPS data through March 31, 2021.

PY = program year; Q = quarter.

D. Characteristics of participants

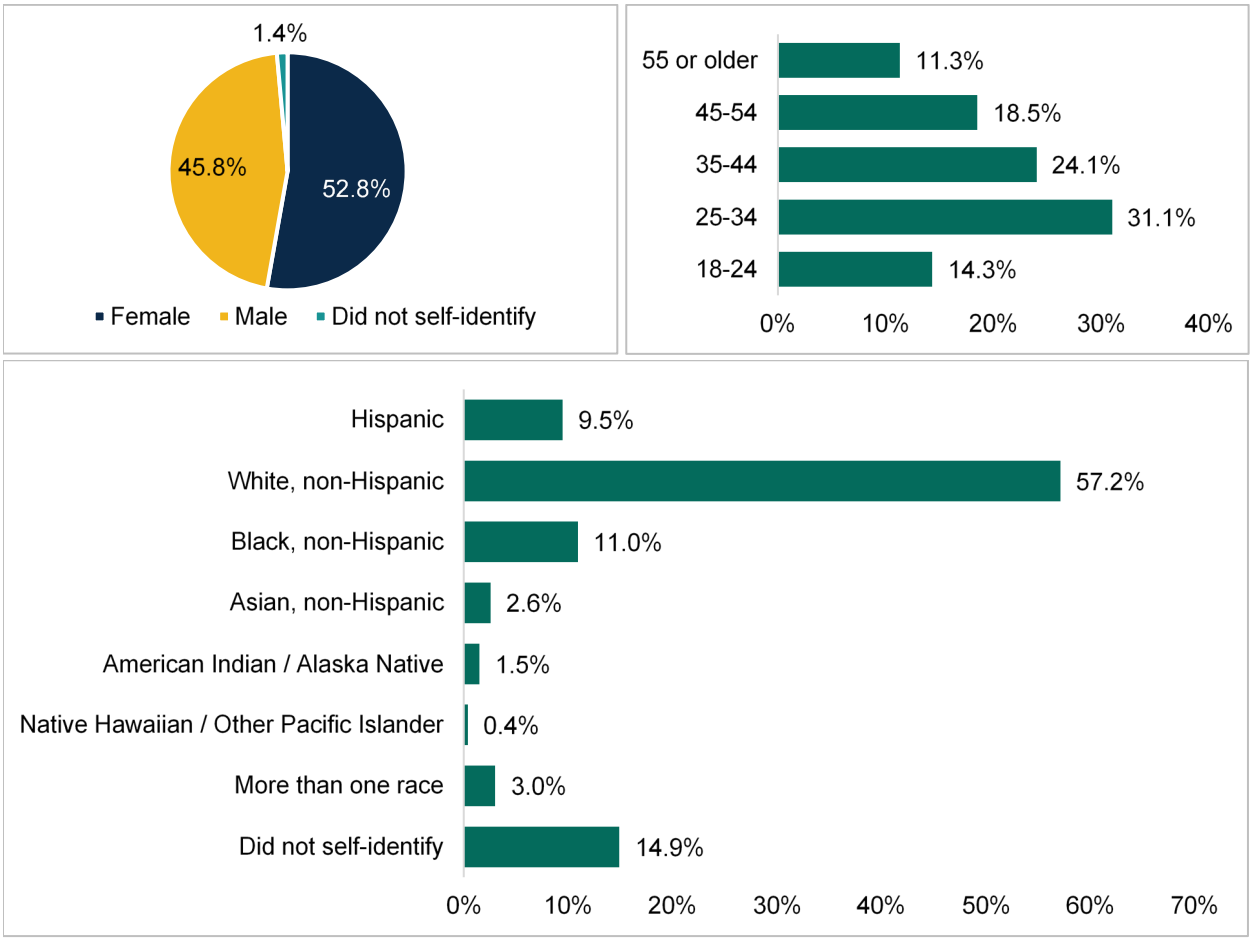
Grantees noted a wide range of backgrounds among participants receiving employment services through the grant, perhaps reflecting the wide-reaching effects of the opioid epidemic. The administrative WIPS data on participant characteristics confirm this diversity. However, grantees did note some key differences between the population receiving grant services and the general population receiving workforce services—particularly, the need for increased case management among grant participants and a higher prevalence of past justice system involvement. Key characteristics of grant participants include the following:

- **About half of participants served were female, and the average participant was 38 years old at enrollment.** Fifty-three percent of participants were female, 46 percent were male, and the remainder did not self-identify (Exhibit II.3). Grantees enrolled participants across a wide age spectrum, including young adults (14 percent of participants were ages 18 to 24) and older workers (11 percent

of participants were 55 and older). Alaska, whose strategies included a youth transition camp, had the largest share of youth participants (26 percent). Maryland and New Hampshire enrolled the largest share of older workers (16 percent and 17 percent, respectively) [Appendix Exhibit B.2].

- **The racial and ethnic composition of participants varied substantially across states** (Appendix Exhibit B.2). Overall, 9 percent of participants identified as Hispanic; 57 percent as White, non-Hispanic; 11 percent as Black, non-Hispanic; 3 percent as Asian; 2 percent as American Indian/Alaska Native; 3 percent as more than one race; and 15 percent did not self-identify (Exhibit II.3). Alaska had higher shares of participants identifying as Asian and American Indian/Alaska Native, with 7 percent of its participants identifying as Asian and 11 percent identifying as American Indian/Alaska Native . Maryland served the largest share of Black participants, with 39 percent of its participants identifying as Black, non-Hispanic. Rhode Island reported the largest share of Hispanic participants (16 percent).

Exhibit II.3. Demographic characteristics of NHE participants by gender, age and race/ethnicity



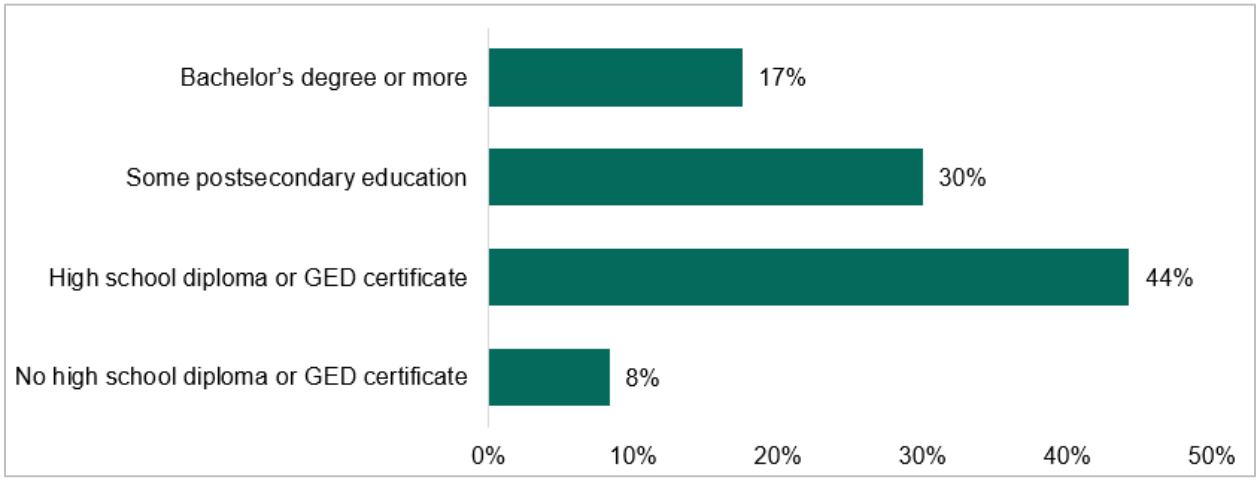
Source: WIPS data through March 31, 2021.

Note: Sample is 2,985 participants enrolled by NHE demonstration grantees through March 31, 2021.

- **Most participants had at least a high school diploma or GED.** Grantees noted a wide range of educational backgrounds among grant participants, from those with limited education and work experience to those with college degrees who held high-level positions before being affected by

opioid use disorder. One respondent described program participants as ranging "from [people who are] homeless all the way up to [people with] two or three master's degrees … from one end of the spectrum to the other." An employment navigator in another state described having clients with very little work experience and with past justice system involvement, while also having a client with a bachelor's degree who was seeking an additional degree to become a substance abuse counselor. The administrative data confirmed staff reports. Over 90 percent of participants had at least a high school diploma or GED certificate (Exhibit II.4). Thirty percent reported some postsecondary education, and 17 percent had a bachelor's degree or more.

Exhibit II.4. Education level of NHE participants

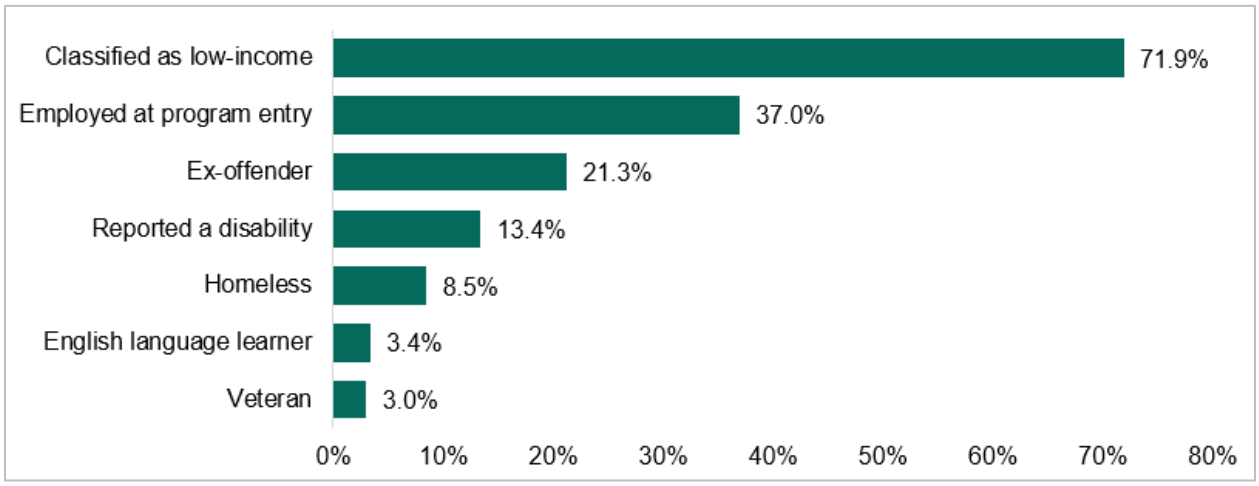


Source: WIPS data through March 31, 2021.

Note: Sample is 2,985 participants enrolled by NHE demonstration grantees through March 31, 2021.

- **Several grantees estimated that a large proportion of participants served through the grant had a history of justice system involvement.** For example, in Washington, frontline staff at one of the two subgrantees (which provided services in a jail) estimated that 75 percent of grant participants had previously been convicted of a crime; the staff at the other subgrantee estimated half of its grant participants were justice involved, noting that jails were important referral partners. Similarly, one subgrant director in Maryland estimated that half of participants were formerly incarcerated or otherwise justice involved, and another estimated that this was true for two-thirds of participants. The administrative data include a self-reported indicator of being an "ex-offender." Twenty-one percent of participants are identified in WIPS as "ex-offenders" (Exhibit II.5).

Exhibit II.5. Characteristics of NHE participants



Source: WIPS data through March 31, 2021.

Note: Sample is 2,985 participants enrolled by NHE demonstration grantees through March 31, 2021.

- **Respondents reported that a large proportion of participants were in recovery.** Although grantees did not ask people to disclose whether they had an opioid use disorder, interview respondents noted that participants in recovery were often open about this and disclosed it to their case managers. As one frontline staff member explained, "[Participants] are usually proud to talk about [their recovery], although we make sure they know that they don't have to disclose." Grantee staff in New Hampshire, Pennsylvania, and Washington, states that purposefully developed new partnerships to recruit participants for the grant, estimated that most participants served were in recovery. Five grantees also trained some of their grant participants to become peer recovery specialists (as described in Chapter III), all of whom were also in recovery from opioid or other substance use disorder.
- **States that used a more targeted approach to identify participants impacted by the opioid crisis enrolled more participants with reported barriers to employment than the states (Alaska and Rhode Island) that used broad approaches to recruitment and eligibility** (Exhibit II.6). States with a more targeted approach (Maryland, New Hampshire, Pennsylvania, and Washington) enrolled more participants who identified as being ex-offenders, as well as more participants who reported being homeless at enrollment. States with a more targeted approach also enrolled more participants who reported a disability and fewer participants who were employed at the time of program entry.

Exhibit II.6. Differences in NHE participant characteristics, by recruitment strategy

		Broad recruitment		Targeted recruitment			
	Overall	AK	RI	MD	NH	PA	WA
Ex-offender	21.3%	7.4%	1.9%	49.4%	24.0%	39.6%	40.1%
Homeless	8.5%	3.5%	0.8%	20.7%	5.0%	7.1%	21.1%
Reported a disability	13.4%	10.0%	2.1%	27.6%	21.3%	26.5%	18.9%
Employed at program entry	37.0%	46.7%	60.8%	18.9%	15.1%	31.7%	9.7%

Source: WIPS data through March 31, 2021.

Notes: Sample is 2,985 participants enrolled by NHE demonstration grantees through March 31, 2021.

AK = Alaska; MD = Maryland; NH = New Hampshire; PA = Pennsylvania; RI = Rhode Island; WA = Washington.

- **Respondents identified a need for intensive case management and supportive services to address other employment barriers.** Respondents noted that grant participants often faced barriers to employment, including lack of reliable transportation, child care, and stable housing. Respondents said this population needed more "hand-holding" and intensive case management than the general population served in WIOA Adult and Dislocated Worker programs. Grant funding available for supportive services aimed to help address some of these barriers to employment.

E. Perceived challenges and strategies related to enrolling participants

Grantees reported several key challenges related to enrolling participants for employment and training services under the grant.

- **Paperwork requirements.** In New Hampshire, Pennsylvania, and Washington, subgrant leadership and frontline staff noted that the required paperwork needed to determine participant eligibility for grant services (such as a birth certificate and Social Security card) were barriers to enrollment. Respondents noted that many people in recovery may have experienced housing instability, may be unlikely to have this kind of documentation in one place, and may need help procuring the documentation needed to verify their identity from various state agencies. Grantees implemented several strategies to address this challenge, including the following:
  - **Using a liaison or an employment navigator** to help participants gather needed paperwork. One subgrantee in Pennsylvania hired a liaison who accompanied potential participants to appointments at government agencies to procure this paperwork and helped them navigate bureaucratic processes. During a focus group with program participants in this area, respondents agreed that they would not have been able to complete all the required paperwork on their own. Similarly, a subgrantee in another state hired employment navigators who helped potential participants access the documents needed to enroll in grant-funded services, as well as helping them access supportive services after enrollment. Subgrant leadership noted that grants like the NHE demonstration grant help them do much more than they can with WIOA dollars. They noted that AJC clients must "jump through hoops to get help" (by providing eligibility documentation before they can receive any assistance) and WIOA is not "as flexible as [they] would want." Respondents noted that a lot of training and time are needed to serve people with opioid use

disorder and said the employment navigators they hired through the grant were key to their success in serving this population.

  - **Issuing a subgrant for pre-eligibility determination.** In New Hampshire, some people whom the recovery centers referred to AJCs for grant services were ultimately deemed ineligible for services due to lack of needed paperwork. Therefore, the grantee issued a small subgrant to a recovery center to help potential grant participants gather needed documentation before connecting with AJC staff. One subgrant leader recommended that more grant funds be available for pre-eligibility services, such as helping participants gather the needed identification and other documents needed for enrollment. There seemed to be some confusion among grantees as to whether the grant could pay for these services. At least two grantees did report using grant funds for this purpose, but one grantee recommended making it a formal component of the grant on which progress could be measured (such as number of people provided pre-eligibility services who were ultimately enrolled in the grant).

- **Participants' discomfort with the AJC environment.** At least four subgrant leaders and frontline staff mentioned that some potential participants with opioid use disorder were uncomfortable going to the AJC on their own, as AJC staff may not be trained to interact with people with behavioral health conditions in a sensitive manner. Grantees recommended training AJC staff on how to interact with people with opioid use disorder, which two grantees did (as described in Section II.B.1). In addition, one grantee had a liaison accompany participants to the AJC. The liaison provided a "warm handoff,"[17] and participants felt more comfortable being accompanied by a trusted person (as described in Chapter III.A.3).
- **Readiness of this population for employment and training services.** Respondents in at least three states discussed challenges in determining whether potential participants in recovery were ready for employment and training services. Grant leadership in one state said they had received many referrals from recovery organizations for people in early recovery whom grantee staff at the AJC did not think were ready for training or employment in a career with advancement potential. Grantee staff said people in early recovery often need a job immediately to pay for housing and other needs while they focus on their recovery; one respondent described this as a "get well job." Employment navigators in another state noted that they encountered some potential participants whom they believed to be actively using illicit substances and said that determining whether these participants were ready for employment was challenging.[18] Strategies used to address this challenge included the following:
  - **Providing supportive services** to meet immediate needs, such as housing, so that participants could focus on training activities (as discussed in Section II.D.1). One subgrantee reported having a few participants who thought they were ready for employment but later decided they were not. Based on these examples, the subgrantee's frontline staff concluded that stable housing, a working phone, and reliable transportation were key indicators of readiness for employment.
  - **Providing flexible employment options,** such as transitional jobs for participants who were unsure about working, needed support acclimating to the work environment, or who wanted to explore various types of jobs (as discussed in Section II.D.2)

[17] "Warm handoff'" is a term from the behavioral health literature that describes referring clients by means of a personal introduction. For more information, please see https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6037516/.
[18] In conducting an environmental scan, we did not find any evidence-based guidelines for assessing readiness for employment for this population or any suggestions that readiness assessments were recommended (Vine et al. 2020).

- **Effects of COVID on participant enrollment.** Grantees that recruited participants in person experienced challenges pivoting to virtual service delivery during the COVID pandemic. For example, one subgrantee in Washington State reported difficulty filling transitional job slots, as it had planned to recruit participants at an AJC when participants dropped by to access services. During COVID, not many job seekers appeared virtually at the AJC. Staff suggested that people with opioid use disorder may not have had access to a computer, the Internet, or other technology. Another subgrantee in Washington that recruited participants through a jail also reported lower enrollments due to COVID.

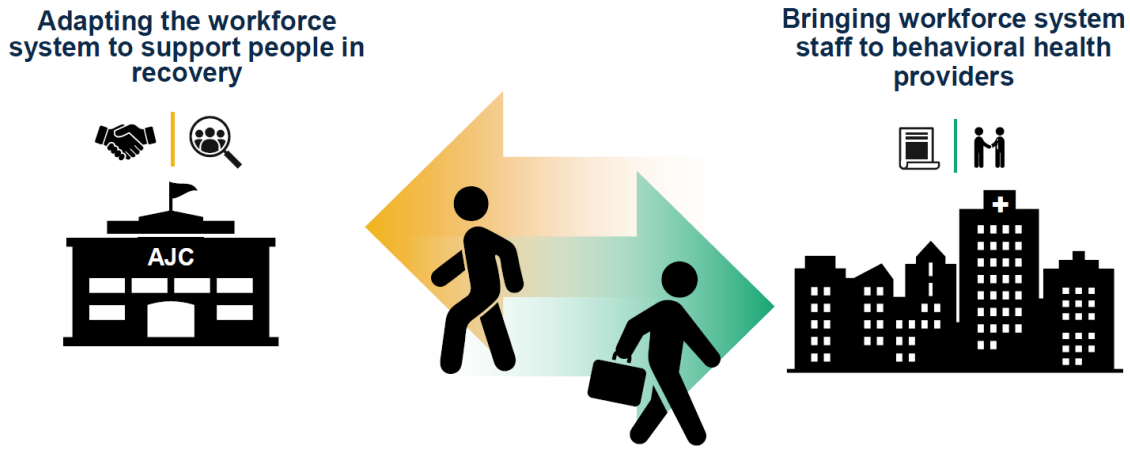
III. Providing Employment Services for People Directly or Indirectly Affected by the Opioid Crisis

Key findings

- Grantees implemented adaptations to the workforce system to make it more welcoming to people in recovery. This included training for AJC staff to better serve people in recovery, reducing caseloads for case managers serving people with opioid use disorder, and having a liaison accompany participants to AJC appointments.
- Four grantees co-located workforce system staff at locations where people received behavioral health services, aiming to reduce barriers to accessing employment and training services for people in recovery.
- All the participants enrolled in the grant received individualized career services. Sixty-one percent of participants enrolled in a training program.

Grantees took different approaches to providing employment and training services to people directly or indirectly affected by the opioid crisis. This included providing employment services through the existing workforce structure, with some adaptations to better serve this population, as well as bringing workforce system staff on-site to behavioral health facilities to provide services in this setting through partnerships with behavioral health organizations (Exhibit III.1). Grantees also implemented strategies to promote paths to employment for people in recovery, including providing supportive infrastructure to promote employment readiness, implementing transitional jobs, and conducting outreach to employers to advance jobs for people in recovery.

Exhibit III.1. Grantee approaches to providing employment and training services to people affected by the opioid crisis



AJC = American Job Center.

A. Adapting the workforce system to support people in recovery

Grantees implemented adaptations to the workforce system to make it more welcoming to people in recovery. These included implementing training for AJC staff to better serve people in recovery, reducing caseloads for case managers serving people with opioid use disorder, and having a liaison accompany participants to AJC appointments and provide "warm handoffs" to workforce system staff.

Training workforce system staff to better serve people in recovery

Rhode Island and New Hampshire used grant funding to train AJC and other workforce staff on how to better serve people with opioid use disorder when providing employment and training services and referrals to behavioral health services. A state grant director reported that this training was developed in response to an identified gap in the skills and training that AJC staff were receiving. noting that most training that AJC staff had received was focused on how to help people get jobs, and any training regarding behavioral health was solely about external services to which staff could refer people with behavioral health challenges. An administrator noted that AJC staff may see the opioid epidemic as a problem other areas experience, without realizing it is "in their backyards" and that they likely interface with people with opioid use disorder even if they do not realize it.

> **"What we have found … is that there is an absence of routine and robust professional development for frontline staff who work in AJCs. With the … pervasiveness of the [opioid] epidemic, this was an area that quite clearly became one where we were not having enough training and our staff were not well equipped to handle being on the front line of that epidemic, whether they know it or not."**
>
> ***Grant administrator***

The grantees sought to develop training that would inform AJC staff about what it means to have a substance use disorder and be in recovery, and how substance use disorder affects a person's ability to find and keep work. In addition, grantees aimed for the training to provide a broad overview of the opioid epidemic, how AJC staff might interact with people with opioid use disorder in their jobs, how to be sensitive in their word choices when talking about substance use, and referral resources available in the community. Respondents said that staff particularly needed training on the use of non-stigmatizing language (for example, saying "person with opioid use disorder" or "person in recovery" rather than "addict" or "former addict").[19] Finally, grantees sought to make AJC staff aware of how people with histories of substance use might have interacted with the criminal justice system and what that could mean for job opportunities.

The intensity of these training efforts differed in the two states. New Hampshire engaged a training provider (the state's Recovery Coach Academy[20]) to provide a one-day training called "Foundations of Addiction and Recovery" to all client-facing AJC staff near the beginning of the grant period in May 2019. Rhode Island used grant funds to develop a new training curriculum to be used for successive cohorts of AJC and CBO staff providing employment and training services. Rhode Island's virtual training included four hours of facilitated training, led by an experienced trainer from Rhode Island College, and group discussions among participants in breakout rooms. Participants then completed an additional four hours of training through self-paced online modules.

[19] For more information on person-first language, please see https://www.drugabuse.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction.
[20] For more information about the Recovery Coach Academy, please see http://nhrecoverycoachacademy.com/.

In the initial planning phases of curriculum development, subgrantee staff in Rhode Island held conversations with the executive directors of workforce agencies to find out what gaps agency staff were seeing. They then conducted a survey of CBOs providing workforce development services to obtain input about their needs in serving people with opioid use disorder. Using feedback from the conversations with workforce directors and these surveys, subgrantee staff developed a curriculum that aimed to meet the needs of local workforce agencies. The Rhode Island Department of Health reviewed the curriculum as well. Exhibit III.2 lists topics included in Rhode Island's curriculum.

> **"It was an all-day training where a woman came in and taught us about opioid addiction and how it affects the brain, which opened my eyes to not judging this population. The woman who ran training was in recovery herself and told us her story and what she has overcome … It opened my eyes since I didn't have a background of working with this population. That was very helpful and stuck with me."**
>
> ***Frontline staff respondent***

Both states provided the training to frontline AJC staff who interact with clients, such as job developers and career navigators; in Rhode Island, CBOs providing employment services also participated in the training. Frontline staff in New Hampshire who participated in training praised the training, with one noting that it was one of the best trainings they had ever attended. Although Rhode Island was just starting to implement its training in January 2021, subgrantee staff reported initial successes as being able to adapt the training to an online format and collaborating with a partner to drop off free naloxone kits to participants at the end of the program.

Exhibit III.2. Key topics in Rhode Island's training curriculum for AJC and CBO staff

- Overview of behavioral health and substance use
- Social determinants of health
- Interpersonal skills and cultural competency
- Opioid support resources in Rhode Island
- How to administer naloxone (an overdose-reversing drug

Despite these successes, there were a few reported challenges implementing these training programs for workforce system staff. Respondents noted that behavioral health and opioid use disorder are not "front of mind" for AJC staff and, although AJC leadership was very supportive of this training, not all AJC staff were initially excited to participate in training on this topic. One respondent thought receptivity to conversations about behavioral health might differ among generations, with older staff at AJCs being less receptive. However, grant leadership believed that once participants attended the training, they realized the importance of the topic. This aligns with the experiences we heard from frontline AJC staff who had highly positive feedback about New Hampshire's training, particularly those staff members who did not have prior experience working with this population. Subgrantee staff in Rhode Island said sustaining this program beyond a one-time training was challenging, but the state hoped to incorporate this curriculum into existing weekly professional development sessions for AJC staff.

More intensive case management for people with opioid use disorder

In at least three states, respondents reported that workforce system staff needed to spend more time on case management when serving people in recovery from opioid use disorder. Frontline staff at AJCs said developing a resume or filling out an application can be overwhelming for people in recovery and

recommended keeping caseloads low for case managers working with this population. In New Hampshire, state grantee staff who administer the WIOA program noted that for other populations, having a touch point every 30 days has been sufficient to keep those clients engaged and lead to positive outcomes; with the population served through this grant, however, a touch point every 30 days was not nearly enough—almost daily contact was required. Similarly, staff of a subgrantee providing employment services in Pennsylvania said having smaller caseloads of 5 to 10 participants per week for their frontline staff was a key feature that led to the success of employment services they provided at treatment clinics (see Strategy Spotlight 1). In Washington, both local areas that received subgrants reported the need for "hand-holding" of participants, who needed case managers to help guide them through services and navigate the social safety net system. Staff in both local areas remarked that to prepare grant participants for employment, case management needed to be more intensive than it was for other clients. In one local area, subgrant leadership thought that participants who were most successful in employment were those who had outside social service or case management support (through a recovery organization, for example).

Having a liaison accompany participants to AJC appointments and provide "warm handoffs" to workforce system staff

A subgrantee in Pennsylvania went a step further in providing a unique case management service to grant participants by hiring a liaison to accompany participants to their appointments at the AJC. The liaison conducted outreach to organizations in the community serving people in recovery, such as halfway houses, to recruit grant participants. The liaison also maintained strong connections with grant participants after they were enrolled in services and helped them navigate the AJC system.

The subgrantee (a local workforce board) knew that the AJC setting could be intimidating to people in recovery and sought to hire someone who could build trust with program participants. This liaison first met with participants one on one in the community in a comfortable setting (such as their home or a restaurant), rather than in a formal office setting. Once they built trust and participants felt comfortable with the liaison, the liaison worked to determine their needs. The liaison had a discussion with potential participants to gather background information, including whether they had a criminal record, their stage of recovery, and their desired profession, and then accompanied them to the AJC.

The subgrant director noted that participants were very uncomfortable in the AJC system; the building has an open floor design and they have to register at the desk, which can be intimidating. Before participants went into the AJC with the liaison, the liaison helped them put together a packet of information with everything they need (such as a Social Security card, birth certificate, or driver's license) to prevent barriers to enrollment.

> **"Participants respect [the liaison]—his phone rings all of the time. He builds very good connections with them … [this population needs] a direct link to someone, it can't be 'call this number and tell this person what you need.' He is not a navigator—he is more like a concierge. This population needs warm handoffs and to be anchored to someone. They need contact outside of that 'cubicle world.'"**
>
> ***Subgrant respondent***

In addition to helping potential participants gather the needed paperwork for eligibility determination, the liaison also helped remove barriers to employment; for example, he has helped program participants get past felonies expunged from their criminal records. The liaison also checked in on participants after they began receiving training. For example, program participants going through peer recovery specialist training noted in a focus group that the liaison went

out of his way to help them by attending their first day of training class to check in with them and see if everything was going well in class. The local workforce board also asked participants to complete consent forms allowing the liaison to share information with their career navigators in the AJC. One subgrant respondent felt strongly that the liaison was key to the program's success in working with people in recovery and keeping them engaged in grant services.

B. Locating workforce system staff within behavioral health organizations

In addition to adapting the workforce system to make it more welcoming to people in recovery, four grantees co-located workforce system staff at locations where people received behavioral health services. Through partnerships they developed with behavioral health providers, these grantees reduced barriers to accessing employment and training services for people in recovery by providing services on-site at locations where potential participants already gathered. Strategies included embedding workforce services in a community resource center, an outpatient treatment clinic for opioid use disorder, a residential treatment facility for substance use disorder, and at recovery community organizations.

In four states, subgrantees that were interviewed developed partnerships with behavioral health organizations to provide workforce services on-site at a facility in which participants were already receiving opioid use disorder treatment or recovery services. In one case, a subgrantee in Washington engaged partners to provide workforce services at a community resource center (a "one-stop shop") that had opened in 2018 as a hub for community services, including housing, mental health, and substance use treatment. When the NHE demonstration grant was awarded, several partners committed to providing grant-funded workforce services at this community resource center, including the local workforce system and several local community-based organizations that provide employment services. A subgrantee in Pennsylvania that operates several outpatient opioid treatment facilities and also operates an AJC brought workforce staff on-site to provide employment services to program participants receiving outpatient treatment for opioid use disorder at the facility. In Maryland, a local workforce development area, provided employment training to people in treatment for substance use disorders through a partnership with a residential treatment provider. Residents typically lived in this residential treatment home for six to nine months; the local workforce board staff came on-site to provide services. New Hampshire adapted a work readiness curriculum that was usually offered in a community college environment and offered it at recovery community organizations along with "job club" sessions that were offered on a drop-in basis.

Across these four states, respondents noted several features that were key to the success of providing workforce services on-site at behavioral health facilities:

1. **Developing trusted partnerships with behavioral health staff to provide integrated care**

   Workforce system respondents in all four states noted the importance of developing trusted partnerships with behavioral health treatment providers, who might initially be skeptical of workforce system staff and worry that they might detract from participants' focus on their recovery. One respondent noted that the treatment providers at an outpatient treatment clinic were initially nervous about their clients entering employment, but workforce system staff were able to build trust with the behavioral treatment providers by spending time at the treatment facility, attending group counseling sessions, getting to know the staff, and ensuring that clients' employment would not interfere with their treatment schedule. The subgrantee in Washington providing employment-related services in a community resource center said this integrated format was very helpful for treating clients holistically and allowing for more collaboration between service providers. The subgrantee staff noted that having employment services at the same place where participants were receiving behavioral health

services removed structural barriers to access because services were all within the same building, thereby reducing difficulty associated with having to travel to multiple locations for services, schedule multiple appointments, and provide the same documentation to multiple agencies.

2. **Adapting employment services and work readiness training for use in behavioral health settings**

   At least two respondents from the workforce system noted that when providing services in behavioral health settings, they needed to be flexible in adapting their usual resources to fit better within the context of participants' treatment. For example, a respondent from the workforce development board in Maryland providing employment services at a residential treatment home noted that they worked with the treatment provider staff to develop an employment service curriculum that could be integrated into the day-to-day recovery curriculum used at the facility. In addition, this subgrantee partnered with a local community college to provide additional work readiness, financial literacy training, and computer training to residents who wanted to work on these skills. When adapting work readiness training for people in recovery, New Hampshire involved recovery centers in curriculum development, which was important for generating their buy-in and support for hosting the work readiness trainings on-site at their facilities.

3. **Providing flexible employment options for residents in treatment**

   A key feature of three of these states' programs is that they allowed participants to work while simultaneously receiving treatment for opioid use disorder. Programs treated the participants in an integrated, holistic way rather than requiring participants to complete their treatment before starting employment. In two cases, this involved transitional employment that allowed program participants to ease into working again. For example, the residential treatment center that hosted employment training services on-site also offered employment opportunities through which residents could gain work experience; such employment opportunities included making, packaging, and marketing chocolates (which are sold online and at a local business); bathing and grooming dogs; and removing junk from homes and businesses in the community surrounding the treatment center. Participants in focus groups appreciated being able to earn money and develop marketable skills while they were in treatment. Similarly, the subgrantee providing employment services at an outpatient opioid treatment clinic offers flexible employment options by partnering with employers that can offer work shifts that will accommodate participants' methadone treatment schedule.

> **"They allowed me to work while in treatment. I was also able to slowly get back to school. I have small children, so they allowed me to work at my own pace and not go above and beyond as a part of being in a long-term facility. A lot of other programs want [you] to go right back to work before [you] are ready. For me it was helpful to focus on the areas I needed to and get back [into] the swing of a life of sobriety."**
>
> ***Program participant***

In terms of implementation challenges, developing trust between behavioral health treatment providers and workforce system staff takes time and was reported as an initial challenge for two subgrantees. One respondent from the workforce system who provided work readiness training on-site at recovery centers noted, "It took a long time to develop the program and get people to buy into it. Some recovery centers were skeptical and had the attitude of doubting what we knew about recovery since we came from the [workforce] system." A subgrantee in another state echoed this, noting that it took time for staff from the two systems to trust each other and find the "balance between employment and treatment" and figure out how to provide services using an integrated approach, while recognizing that employment and treatment

would not detract from each other. Key factors respondents noted in overcoming this challenge were the importance of open communication and getting input from behavioral health providers on the best way to deliver workforce services for people in recovery.

C. Paths to employment for people in recovery

Strategies that grantees used to develop paths to employment for people in recovery included (1) providing supportive infrastructure to support employment readiness, including supportive services and work readiness training, (2) transitional jobs, and (3) outreach to employers to develop jobs for people in recovery.

Providing supportive infrastructure to support employment readiness

To address participant readiness for employment, grantees implemented a number of strategies including readiness assessments to understand participants' stage of recovery and behavioral health needs, supportive services to meet immediate needs such as housing, and tailored work readiness trainings and soft skills trainings.

When using readiness assessments to understand participants' readiness for employment, respondents in three states (Maryland, Pennsylvania, and Washington) noted that they paid particular attention to the behavioral health needs of participants in this grant and recognized that grant participants might be more likely to need supportive services or referrals to behavioral health providers. For example, one subgrantee in Maryland providing employment services through a CBO used a specialized in-house assessment for grant participants during intake that captured demographic information, employment history, previous substance use and treatment history, family/household status, and criminal justice system involvement. A coach conducted the assessment with interested people, and a mutual decision was made with the individual about whether to move forward with either group training or individualized one-on-one coaching. The subgrantee would refer participants to behavioral health specialists to address their opioid use disorder treatment needs and would take into account treatment-related recommendations from the behavioral health specialists in working with clients on job training and placement. Permission from the participant would be required for the behavioral health specialist to share such information with the workforce staff.

Pennsylvania provided training on Screening, Brief Intervention, and Referral to Treatment for case managers, other frontline staff, and supervisors at the AJCs in the four local areas of the state that participated in the grant. [21] Although not a method of assessing readiness for employment, this training focuses on identifying people with opioid use disorder and referring them to treatment, which is designed to remove barriers to employment. In the other three states (Alaska, New Hampshire, and Rhode Island), grantees used standard assessments they use for all workforce customers and did not tailor them to the population in recovery.

[21] For more information on Screening, Brief Intervention, and Referral to Treatment, please see https://www.samhsa.gov/sbirt.

Strategy Spotlight 1: Embedding employment services in an opioid treatment facility

Implementation context

In Pennsylvania, subgrantee Philadelphia Works, Inc. partnered with JEVS Human Services to implement the National Health Emergency (NHE) demonstration grant. JEVS Human Services offers both employment and training services and behavioral health treatment and recovery services. JEVS operates one of the four Pennsylvania CareerLink® Philadelphia (American Job Center) sites located in Philadelphia, through which its staff provide services to job seekers (such as job search, placement, retention support, and other career services to individuals) as well as outreach to employers. At the same time, JEVS runs two outpatient, state-certified opioid treatment facilities in Philadelphia, known as Achievement through Counseling and Treatment (ACT) I and ACT II.[22]

Key intervention components

Through the NHE demonstration grant, JEVS brought employment staff from CareerLink®, who had not previously worked with people with opioid use disorder, on site at the opioid treatment facilities to recruit participants and provide employment services. It also established a partnership with Jefferson University Hospital (one of the other subgrantees) to provide on-site employment services at Jefferson University's outpatient methadone treatment program two days per week.

Through this program, a team of three JEVS employment staff (a program manager and two employment advisors) established on-site offices at the three treatment facilities to offer job search assistance, resume development, mock interviews, and other services specifically tailored to the recovery population. A program manager, who had previously worked at PA CareerLink®, noted that spending time on site at the treatment programs and developing trust with the staff and clients was very important. She This respondent said they even changed the way they dressed to be less intimidating to the clients.

JEVS staff noted that providing employment services on site at a treatment clinic was very effective for this population, who would be intimidated to go to PA CareerLink® on their own. Meeting people where they already were for treatment made employment services more accessible to participants, as they did not have to take an extra step of going to an outside agency. One staff member reported they adapted the services provided at PA CareerLink® for this population because they thought the assessments they usually used would be too cumbersome for this population and they would not remain engaged if there were too many steps in the enrollment process. To be more flexible with the enrollment process while still meeting the grant's intake information requirements, staff had one-on-one meetings with potential participants to engage them in the program and discuss their skills and job interests, rather than having them fill out a formal assessment. Staff also talked to potential participants about the paperwork needed to register them under the grant, such as a Social Security card or birth certificate, and would refer them to the appropriate government agencies if they had to obtain these documents.

> **"To enroll individuals in the program, you can't overwhelm them with too much paperwork. They won't remain engaged. We talk to a client, get them engaged and get their resume done and may even send it out [to employers] at their first session."**
>
> ***Interview respondent***

To advertise available employment services, JEVS employment services staff put up fliers around the treatment facilities and gave short presentations to introduce the program in group counseling sessions, which clients attend on a regular basis. The JEVS employment staff also explained the program to all the behavioral health counselors and other staff at the treatment facilities so they could refer clients they thought were ready for employment to the program. The three JEVS staff members said some people sought services after hearing about the program and counselors referred others; staff then met one on one

[22] These outpatient treatment facilities provide methadone as well as group counseling, individual counseling, case management, and other services. For more information, please see https://www.jevshumanservices.org/program/achievement-through-counseling-and-treatment/.

with potential grant participants to judge whether they were ready for employment. Criteria staff used to judge potential participants' readiness for employment included their stage of treatment and whether they had stable housing.

Potential elements for success

Interview respondents believed the following ways in which they tailored the employment services available to this population were important aspects of implementation:

- **Simplified assessment and enrollment, smaller caseloads, and longer follow-up.** As noted above, employment staff simplified the assessment and enrollment process. In addition, they also had small caseloads of 5 to 10 participants per week, which enabled them to check in with participants frequently (once a week or every two weeks) and spend more time with participants to support their needs. JEVS employment services staff also continued to provide support to participants for three months after they became employed, and even after three months participants could still reach out to JEVS staff if any issues arose in their jobs.
- **Use of incentives.** The program also provided participants with a $125 gift card incentive when they got a job and additional gift cards of $50 after the first month of employment, $75 after the second month, and $100 after the third month.
- **Focus on preparing for the job search and conducting mock interviews with participants.** Staff noted the particular importance of helping participants learn how to describe during a job interview any involvement in the criminal justice system. For example, as part of this preparation, participants learned that they could include on a resume the work assignments they performed in jail and use that experience to describe marketable skills.
- **Focus on participants' preferences**. JEVS staff recognized and accommodated participants' preferences in regard to several factors: some participants preferred to ease into employment through a part-time job rather than seeking full time work; and many participants sought to access immediate employment, rather than participating in training programs. JEVS staff allowed participants this flexibility rather than prescribing a set of services they must participate in through the grant.
- **Outreach to employers.** Staff reached out to employers about this program and worked with employers that indicated their willingness to hire people in recovery. Staff provided information to the employers about participants being on methadone and their need for work shifts that accommodated their treatment schedule (because many participants have to visit the methadone clinic daily in the morning to receive their medication.)[23]

Implementation challenges and strategies

Three JEVS staff reported providing employment services was a new concept for behavioral health counselors and other clinic staff. Initially, when the program started, these JEVS staff perceived that the behavioral health treatment providers felt treatment for opioid use disorder should be clients' number one priority and were nervous that entering employment could take away from clients' focus on recovery. To build trust with the counselors and other behavioral health providers, JEVS employment and training staff had conversations to explain that they were not trying to interfere with people's recovery but believed employment could actually help people be more successful in their recovery by giving them hope for the future. Over time, by attending counselors' group sessions with clients and talking to them about the possibility of employment, the JEVS employment and training staff gained the counselors' trust. An additional challenge was that when the grant began, JEVS had anticipated that many participants would be interested in obtaining a GED and engaged a GED instructor to work with participants. Instead, JEVS staff reported that participants preferred to begin employment directly; JEVS therefore focused on placing clients in employment rather than promoting GED instruction and other training programs.

[23] We caution, however, that such an approach should be taken only for participants who give staff explicit permission to share their recovery and treatment status with prospective employers.

Grantees used both **formal readiness assessments and informal methods** to assess participants' stage of recovery and readiness for employment. One subgrantee offering transitional jobs used a standardized employment assessment called the Employment Readiness Scale to determine whether a participant was ready for a job; employment navigators reported that it gave them and the participant an idea of what areas they needed to work on to increase their employability and of whether the participant was "job ready." In other cases, workforce system staff had informal conversations with program participants to judge their readiness for employment and determine their social service needs; common factors judged as indicators for employment readiness included stable housing and transportation.[24] In cases where potential participants were not judged ready for employment services, they were generally not enrolled in grant services but were referred to partner organizations that provide wraparound services.

> **"If [participants] are in a recovery center, they have to pay rent too while they're there. So that's kind of challenging for them. They are all of [a] sudden thrown into the workforce, and they need a job right away. But that's where we can kind of come in and help with the first or second month's rent so that they can settle down and get back into the workforce … that just kind of keeps the burden off them [so they don't feel like], 'I need a job right now. It doesn't matter what it is.'"**
>
> ***Frontline staff member***

A theme across all six grantees was the importance of **supportive services** for this population in promoting employment readiness. Common services that the grant funded included transportation (such as bus passes, gas vouchers, car repairs, and car insurance vouchers), rental assistance, utility bills, and child care. Frontline staff noted that these supportive services could be particularly helpful in reducing barriers to participating in trainings. They noted that people in recovery have many immediate needs, such as transportation and housing, and may be more interested in seeking a job for immediate income; however, addressing some of these needs through grant funding made participants more open to participating in, for example, a month-long training program prior to employment. Grantees also provided supportive services to participants when they began working, such as professional clothing needed for a new career or background clearances and fingerprinting required by some employers. The amount of funding that grantees reported allocating per participant ranged from $500 to $1,000.

At least two grantees also leveraged partnerships with other organizations providing supportive services, particularly housing. For example, the Rhode Island NHE grant coordinated with the State Opioid Response (SOR) grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) that funds recovery housing (among other services). An NHE demonstration grantee staff member recruited people seeking employment and training services who were living in recovery housing. An advantage of this arrangement was that the NHE grant did not have to address housing needs for these participants because their housing needs were already being met by the SOR grant. A local workforce development board (LWDB) subgrantee in Maryland had a similar arrangement whereby, through the grant, the subgrantee provided on- and off-site employment and training services for people living in a residential treatment center; the NHE grant then funded supportive services when people moved to transitional housing after six to nine months of treatment.

[24] Although some sites felt stable housing was necessary for job readiness, research has documented that people who are homeless can work. For example, the 1998 *Final Report on the Job Training for the Homeless Demonstration Program* prepared for the DOL Employment and Training Administration found that, of 35,000 participants who received employment and training services, about 16,500 obtained employment. Report available at https://wdr.doleta.gov/opr/FULLTEXT/jthdp/jthdp.pdf. Accessed July 28, 2021.

In addition to supportive services, grantees provided **work readiness training** focused on soft skills, with several tailoring the training specifically to participants in recovery. Subgrantees in four states tailored existing soft skills training curricula to focus on topics most relevant to people in recovery, such as explaining gaps in their resume, discussing past justice system involvement, deciding whether to discuss one's recovery with potential employers, and informing employers about any schedule adjustments needed to accommodate their treatment schedule once hired. A subgrantee in Washington offering jail-based employment services described their soft skills training as helping inmates develop an "elevator pitch" in preparation for release. Other grantees offered work readiness trainings similar to those usually offered at AJCs to populations facing many barriers to work, such as those who have experienced homelessness (many of whom also have substance use disorders). In New Hampshire, the state initially promoted its standard work readiness training but soon realized the training needed to be tailored to be more relevant and accessible to this population (see Strategy Spotlight 2).

Grantees experienced a few challenges providing supportive services. Although grantees found the supportive service funding allocated through the grant helpful, the state administrator and subgrantees in one state cited a need for even more funding for services such as housing, transportation, and child care. This challenge also came up in the focus groups with program participants in at least two states. Program participants also noted that this aspect of the grant could have been more broadly publicized to participants. For example, one program participant noted, "When I was in the program, I was less aware that any supportive services were available, but now that I am on the other side of it, I am more aware. Providing more information about what is available would be more helpful." In other cases, program participants described having a hard time getting vouchers for supportive services such as car insurance. Respondents indicated that the process seemed cumbersome and, although it was touted as a potential service, it was not actually available. On the other hand, one grantee perceived that although its referral partners appreciated the supportive services that were available, in a few cases, people were seeking out grant services for the sole purpose of accessing supportive services. The grantee reported that it needed to be clear that services such as rental assistance were available on a short-term basis to help program participants complete training programs or gain employment, rather than as a stand-alone benefit.

Offering transitional job placements

Subgrantees in two states, Washington and Maryland, offered transitional jobs to participants through the NHE grant. Transitional jobs, also known as subsidized work experience, involve placing participants into subsidized positions with partner employers. In Washington, the jobs typically lasted for 300 hours, whereas in Maryland they lasted for 16 to 20 hours per week during part of the six- to nine-month period in which residents were living at a residential treatment facility. Subgrantee staff in Washington described several reasons for using the transitional jobs approach: (1) employment is itself part of treatment, as employed people are more likely to remain successful in recovery than those who are unemployed; (2) employment helps participants have an income right away, which is a support to themselves and their families; and (3) immediate and subsidized employment helps build participant work experience, as well as strengthening resumes and developing references participants can use for future job searches.

Strategy Spotlight 2: Adapting work readiness training for people in recovery

Implementation context

Before the National Health Emergency (NHE) demonstration grant, New Hampshire had a work readiness program called WorkReadyNH, which it offered free of charge to customers receiving services through AJCs. Before shifting to a virtual format during the COVID-19 pandemic, WorkReadyNH was offered at community colleges in the state. The program consisted of a 60-hour course offered over a three-week period: it covered soft skills as well as online math and reading tutorials, and included an assessment at the end that enabled participants to earn a National Career Readiness Certificate issued through American College Testing (ACT).

When applying for the NHE demonstration grant, state workforce leadership anticipated many participants affected by the opioid crisis would participate in this training. However, after the grant began, state grant staff and referral partners realized the traditional WorkReadyNH program did not meet the needs of participants in recovery, some of whom were not comfortable in the community college environment. Further, grantee staff recognized that the training needed to be tailored to issues specific to people in recovery. In addition, grantee staff perceived that attending a full-time, three-week course was not realistic for all of these participants for several reasons, since some wanted or needed to start working quickly or had various appointments (such as drug court) that would have affected their attendance. Grantee staff recognized the need for a program with a flexible schedule and the state grantee issued a subcontract to the Community College System of New Hampshire (CCSNH) to develop a work readiness curriculum specific to the population in recovery, which was called Bridge to WorkReadyNH.

Key Intervention Components

The Bridge to WorkReadyNH program focused on soft skills and topics specific to people in recovery, such as how to account for gaps in employment, how to discuss past incarceration, and the pros and cons of discussing one's recovery during job interviews. CCSNH developed the curriculum by tailoring a soft skills curriculum through consultations with multiple recovery centers in the state. The Bridge to WorkReadyNH Curriculum was 30 hours total, to better meet the time constraints of people in recovery.

Bridge to WorkReadyNH training modules

- Self-leadership
- Communication
- Collaboration
- Organization and time management
- Getting your job search started

Rather than offering the sessions at a community college, the state grantee worked with recovery centers to host the Bridge to WorkReadyNH class at the centers, which they believed would be more welcoming to people in recovery. Since the COVID pandemic began, the class had been offered through six self-paced, interactive modules and three virtual classes scheduled at varying times throughout the week. Upon completion of the program, participants earn a certificate. CCSNH had also connected with corrections facilities to deliver the class (both in person and virtually during the COVID-19 pandemic) while participants are incarcerated, which two respondents reported had been a successful way to recruit program participants.

Potential elements for success

Although take-up of the program was not as high as grantee staff had hoped , interview respondents shared a number of lessons learned and advice for those offering similar programs. Respondents perceived several factors as important to implementation:

- **Involving recovery centers in curriculum development.** Respondents believed involving recovery centers in the curriculum development process was helpful in generating trust and buy-in to the program.

- **Partnering with corrections.** Respondents described delivering the program in jails as a promising strategy that enabled the grantee to reach more participants, noting that corrections facilities are always looking for programming.
- **Offering programming in residential facilities or recovery housing.** Respondents said they originally sought to engage recovery community organizations because they thought people in residential treatment would not have time to devote to work readiness training. However, in retrospect, respondents thought offering the program in a residential setting might have been more successful because it would be easier to recruit people living there.

> **"You need the input of recovery centers. If you didn't get their help, they would not trust you."**
> ***Interview respondent***

Implementation challenges and strategies

Despite some successes, interview respondents encountered several challenges in implementing this work readiness program. They particularly noted challenges in achieving the participation level for which they had hoped.

Respondents also noted building trust between the workforce system and the recovery centers hosting the program took time. Having recovery centers provide input on curriculum development helped overcome this challenge to some degree. Respondents said building trust was easier after initial cohorts completed the program successfully.

> **"It's tough for people to access these services while they need income at the same time.... If there's any way to work part-time and do this training, that would be beneficial for people"**
> ***Interview respondent***

One interview respondent noted people in recovery often need income to meet their immediate needs, such as for housing and transportation. Although this program was shorter than the original version of WorkReadyNH curriculum, some respondents thought its length was still a barrier to participation. One respondent suggested it would be helpful if participants could take this training while they were already working (for example, through on-the-job training). This respondent noted the soft skills covered in the training are still relevant and beneficial for people after they begin working, in order to help them maintain employment.

Similarly, grant staff had originally envisioned that, after completing the Bridge to WorkReadyNH program, participants would then take the full 60-hour WorkReadyNH program for another three weeks and receive a certificate. However, they soon realized participants could not commit to this additional training because they had to begin working to earn income. Instead, the program began issuing a certificate for completing the Bridge to WorkReadyNH program, reenvisioning it as a stand-alone program.

In both states, the transitional jobs approach had the following key features.

- **Designed specifically for people in recovery.** In both states, the transitional jobs approach was specifically designed for people directly affected by opioid use disorder, many of whom had fragmented or no work experience or had been out of the labor market for many years. In Washington, employment navigators identified participants for placement into transitional jobs at a one-stop human services center (described previously) or at other partner organizations such as jails and treatment centers. Once a participant was determined eligible for NHE demonstration grant services, the navigator conducted a job readiness assessment using the Employment Readiness Scale and, if the participant was interested and deemed appropriate for a transitional job, placed them with one of the participating employer partners. In Maryland, transitional jobs were offered to residents living in a residential treatment facility, allowing participants to work and develop marketable skills while they were in treatment.
- **Focus on CBOs for employment.** In Washington, the subgrantee implementing transitional jobs recruited a variety of employers for placements but primarily focused on CBOs, which were reported as more open than other organizations to hiring people with opioid use disorder. These CBOs included a nonprofit focused on affordable housing, an organization serving refugees and immigrants, and a human services organization. One respondent described these organizations as having "a bit more forgiveness" for the participants who were dealing with opioid use disorder and recovery, and who may have had limited or dated work experience. For example, one CBO partner also operated a retail store, a landscaping business, and a coffee shop where transitional job participants were placed. In Maryland, in addition to on-site employment opportunities at the treatment facility, some residents received job experience through outside employment opportunities—for example, providing cleaning services at a local church or working at a local furniture warehouse.
- **Seeking unsubsidized employment after transitional jobs ended.** In both states, interview respondents reported that they aimed to help participants find full-time employment after the transitional jobs ended, either with the same employer or with another employer in a related field. Subgrantee staff in Maryland noted that their organization has forged connections with local employers, which they believed had helped participants find full-time employment. Staff in Washington also described success stories of participants obtaining full-time employment after their transitional jobs ended, both at the organization that hosted their transitional job or with other organizations, and noted that they have learned to communicate this goal of unsubsidized employment to employers hosting transitional job placements.

> **"The focus of the transitional job is to get [participants] on a pathway to unsubsidized work. It's not just so that they can get paid … it is for a pathway towards unsubsidized employment and so it should have some plans attached to it."**
>
> ***Subgrant director***

The subgrantees implementing this approach thought transitional jobs helped the individual participants and helped reduce stigma among participating employers. According to subgrantee leadership in Washington, transitional jobs were "such a great intervention for those who haven't worked." In particular, interviewed leaders and frontline staff indicated that the transitional jobs program made a big difference in the lives of the participants who were new or newly returned to the workforce. This subgrantee had been looking for an opportunity to test transitional jobs as an employment service strategy, and the NHE demonstration grant provided that opportunity. The subgrantee noted that

transitional jobs cost less than expected, and they considered the strategy a success. Originally, the subgrantee had planned to spend more grant resources on individual training accounts but shifted funds to transitional jobs. The subgrantee in Maryland also considered the transitional work experience a success, particularly for participants in early recovery, in linking participants to full-time employment and reducing stigma among employers: "They've all been able to find full-time employment, once leaving here. Because the other thing it does is it changes the stigma in the community because our [participants] are working. So when [a local business is] hiring us … they actually get to interact with our [participants], engage with them, and they see the lesson: Give the person a chance and you're actually going to have yourself a great employee."

Outreach to employers to develop jobs for people in recovery

Subgrantees in five states reached out to employers that they thought would be interested in hiring people in recovery. For example, a subgrantee in New Hampshire presented information about the grant at chamber of commerce meetings to build awareness among employers in the area. Reports from interview respondents about the willingness of employers to hire people in recovery varied. Some respondents noted that they expected to encounter more stigma from employers but that they learned, unexpectedly, during the grant that employers were more open to hiring people in recovery than anticipated. For example, one state grant director reported that employers tend to realize that people in recovery can do the job as well as other employees, and they did not encounter as much bias from employers as expected. In two states, respondents believed that low unemployment rates (pre-COVID) contributed to employers' open-mindedness. One respondent noted, "At that time our unemployment rate was low, so employers needed people. When the need was greater, employers were more willing to take the chance with those in recovery."

Other respondents noted that employers' willingness to hire people in recovery varied widely by sector. For example, respondents in one state noted that CBOs were generally more open to hiring people in recovery, whereas sectors such as warehousing were more concerned about the focus and ability of people in recovery to safely operate equipment (such as forklifts). Other reported challenges included stigma among employers about the use of medication-assisted treatment (MAT) and the desire of some employers to hire only people who have been in recovery for at least two years, as opposed to people in early recovery. A grantee working with the construction sector noted that employers and unions in the construction sector have become much more open to hiring people in recovery than in the past.

Among grantees conducting outreach to employers interested in hiring people in recovery, respondents noted the importance of highlighting the strengths people in recovery bring to employment. This included highlighting their skills and experience in addition to the fact that they are in recovery. Frontline staff also noted the importance of being open with employers about candidates who may be receiving MAT and need their work schedule to accommodate their treatment schedule. One frontline staff member helping develop jobs for clients on methadone noted, "It's surprising how many employers are open to this idea, as long as you word it correctly. Methadone is a prescribed drug, so they are open to it." This respondent noted that most employers wanted a letter from the participant's counselor indicating that they were in treatment, since methadone will come up on a drug test.

Respondents said they were careful to set up participants in sectors in which they were more likely to be successful in employment. For example, one respondent said they avoided steering participants in recovery toward jobs in the restaurant industry, as they believed they were more likely to be successful in jobs with a more stable schedule than in those with varying shifts. Recovery centers (which often served

as referral partners to the grant) often served as employers as well and hired participants who had completed training as peer recovery specialists. Respondents in four states noted that the required background checks could be barriers to employment in certain sectors (such as health care) for participants with criminal backgrounds; subgrantees in three of these states worked with partners to provide criminal record expungement services for these participants when possible.

Despite these successes, respondents did encounter stigma from some employers toward hiring individuals in recovery. One respondent noted that "stigma around MAT is still an issue and employers need to be educated around that." In another state, respondents noted that some employers were nervous about starting to work with individuals in recovery, and grantee staff pointed out to them that they were likely already working with this population without knowing it. Initiatives such as recovery-friendly workplace initiatives and Project ECHO for employers (described in Chapter V) are aiming to help address this challenge and answer employers' questions about hiring individuals in recovery.

An additional challenge one state experienced was that employers seeking to hire participants in recovery who reached out to AJC staff were not always matched with a qualified job seeker quickly. For example, sometimes the job seekers enrolled in the grant at the time did not match the location where employers were hiring. Interview respondents noted the importance of not over-promising employers how quickly they would be able to send qualified job candidates, in order to avoid damaging these relationships.

D. Receipt of employment services and training

Grantees were required to report information on service receipt, training, credential attainment, and employment outcomes through the WIPS. For the evaluation, we were able to access individual-level WIPS data on services, training, and credential attainment, but we did not have access to data elements that grantees drew from the Unemployment Insurance Wage system, including employment and earnings outcomes.

In the analysis below, we report on the full group of participants as well as the subset of participants who completed their service receipt and exited the program. As of March 2021, 77 percent of participants had exited, and the remainder were still enrolled (Exhibit III.3).

- **Among exiters, the average length of enrollment was 116 days or just under 4 months** (Exhibit III.4). The average length of enrollment among exiters varied substantially across the grantees from a low of about 2.5 months in Rhode Island to a high of over 9 months in Alaska. As discussed below, the longer enrollments in Alaska likely stem from the number of participants enrolled in longer training programs for health care practitioner occupations. Alaska was also an outlier in terms of the share of the participants still enrolled. As of March 31, 2021, only 34 percent of Alaska's participants had exited services (Exhibit III.3).

Exhibit III.3. Receipt of employment and training services, by NHE demonstration grantee

	All	AK	MD	NH	PA	RI	WA
Exited	77.4%	33.6%	82.6%	68.2%	71.0%	83.1%	86.9%
Days enrolled, if exited							
Average (days)	116	278	163	113	137	74	139
Up to 50 days	37.0%	23.4%	12.8%	31.3%	39.6%	48.8%	28.4%
51 to 100 days	22.0%	20.8%	21.5%	23.3%	13.5%	25.2%	20.5%
101 to 200 days	22.2%	11.7%	40.6%	29.5%	19.2%	17.5%	23.6%
WIOA co-enrollment							
WIOA Adult or WIOA Dislocated Worker	41.1%	98.7%	65.7%	5.4%	57.7%	19.3%	55.1%
WIOA Adult	30.1%	52.8%	46.0%	1.2%	50.8%	8.8%	53.7%
WIOA Dislocated Worker	14.1%	67.7%	28.7%	4.7%	6.8%	10.7%	3.9%
Received individualized services	96.7%	100.0%	100.0%	100.0%	97.8%	99.1%	88.1%
Received any training	61.1%	84.3%	53.6%	43.4%	53.3%	95.1%	6.7%
Type of training, if received							
On-the-job training	4.1%	1.0%	7.7%	20.5%	5.6%	2.5%	0.0%
Skill upgrading	6.8%	1.6%	6.3%	0.0%	0.0%	9.9%	0.0%
Customized training	1.1%	0.5%	5.6%	0.0%	5.1%	0.0%	2.2%
Occupational skills training	83.5%	85.5%	81.0%	79.5%	90.8%	82.2%	93.3%
Other training	0.7%	2.6%	2.8%	0.9%	0.0%	0.1%	2.2%
Registered apprenticeship	4.1%	10.9%	0.0%	0.0%	0.0%	5.5%	0.0%
Transitional job	3.6%	0.9%	4.9%	0.4%	0.0%	2.4%	7.1%

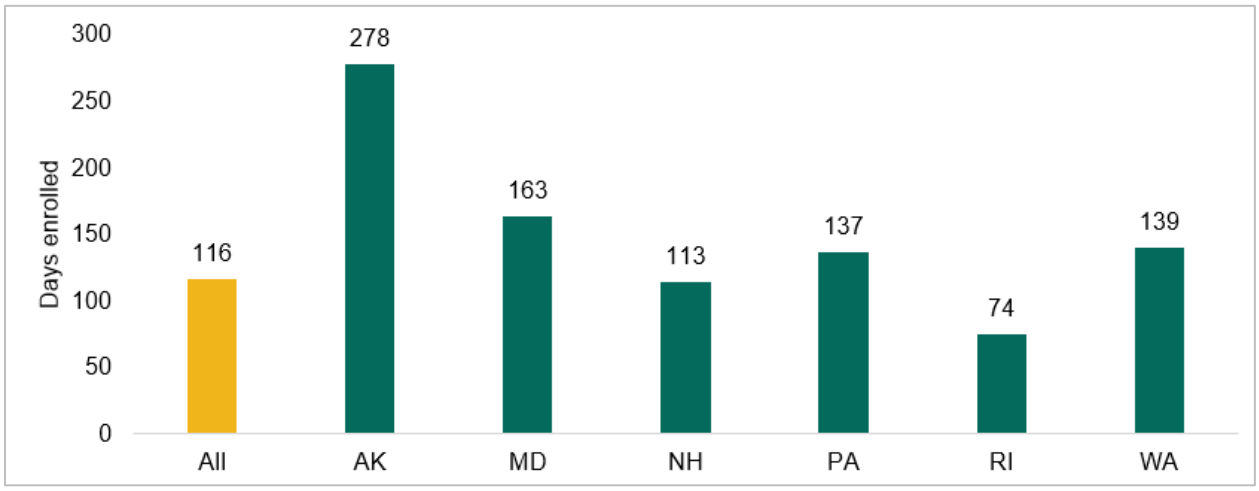
Source: WIPS data through March 31, 2021.

Notes: Sample is 2,985 participants enrolled by NHE demonstration grantees through March 31, 2021.

WIOA co-enrollment refers to individuals who were enrolled in both the NHE demonstration grant as well as WIOA formula programs.

AK = Alaska; MD = Maryland; NH = New Hampshire; PA = Pennsylvania; RI = Rhode Island; WA = Washington; WIOA = Workforce Innovation and Opportunity Act.

Exhibit III.4. Length of enrollment among exiters, by NHE demonstration grantee



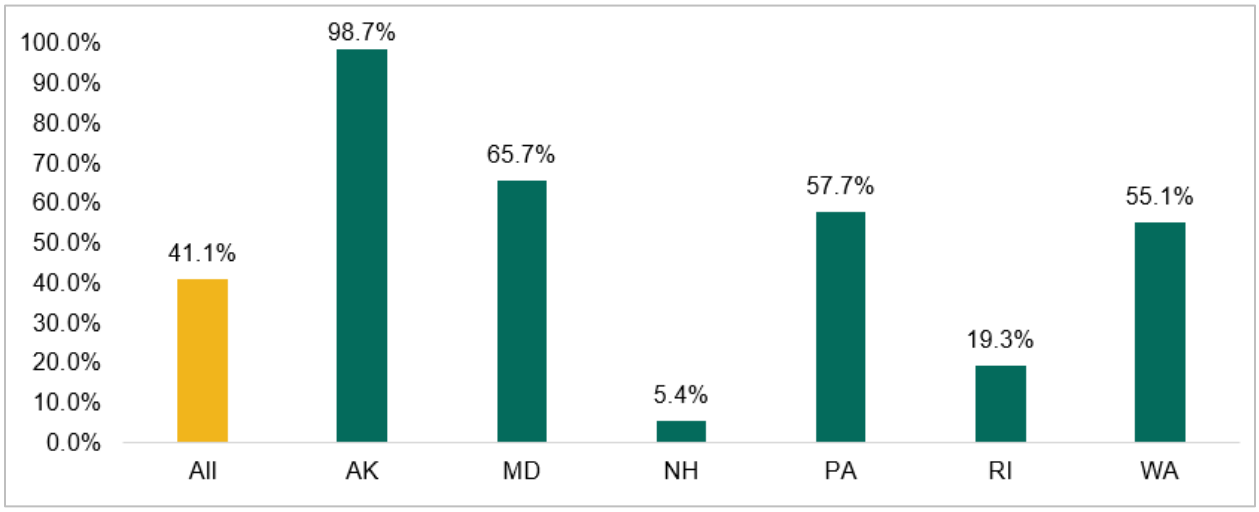
Source: WIPS data through March 31, 2021.

Notes: Sample is 2,309 participants enrolled by NHE demonstration grantees who exited by March 31, 2021.

AK = Alaska; MD = Maryland; NH = New Hampshire; PA = Pennsylvania; RI = Rhode Island; WA = Washington.

- **Almost all participants received individualized career services** (Exhibit III.3). As described above, grantees provided a range of services including development of individual employment plans and work readiness training. Although the intensity of services offered varied across grantees, the WIPS data do not distinguish between a short work readiness session and the much more significant work readiness training offered in New Hampshire.
- **Forty-one percent of participants were co-enrolled in one of the WIOA formula programs** (Exhibit III.5). The initial TEGL authorizing the grant encouraged states to "co-enroll grant participants in WIOA formula programs, where appropriate, to maximize the impact of these grant funds and ensure the delivery of the full range of necessary services" (DOL 2018). Co-enrollment in the WIOA Adult program was more common than co-enrollment in the WIOA Dislocated Worker program. The co-enrollment rate varied substantially across the grantees from a low of 5 percent in New Hampshire to a high of 99 percent in Alaska (Exhibit III.3).

Exhibit III.5. Co-enrollment in WIOA Adult or Dislocated Worker programs, by NHE demonstration grantee



Source: WIPS data through March 31, 2021.

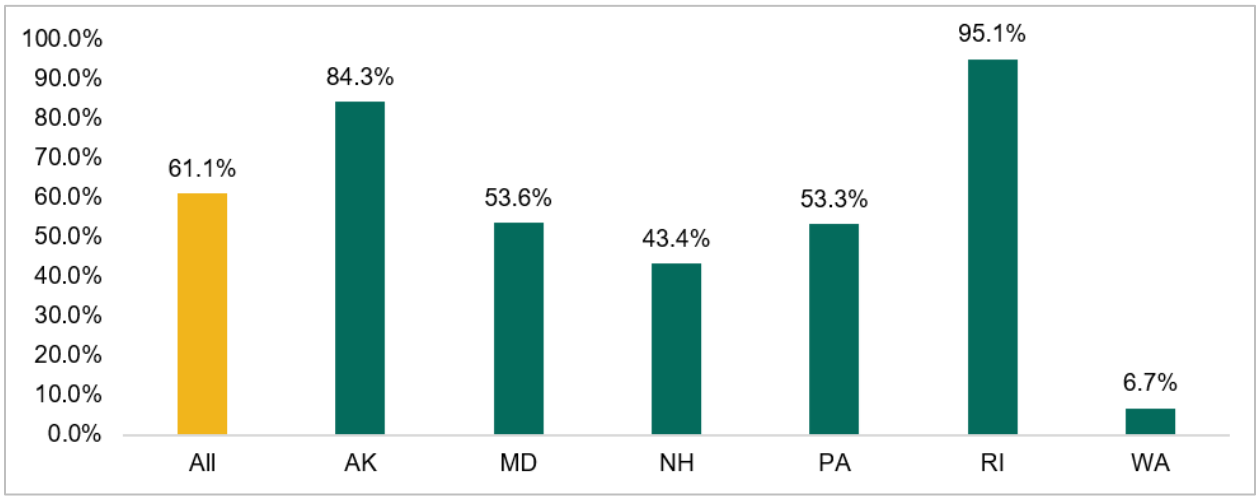
Notes: Sample is 2,985 participants enrolled by NHE demonstration grantees through March 31, 2021.

WIOA co-enrollment refers to individuals who were enrolled in both the NHE demonstration grant as well as WIOA formula programs.

AK = Alaska; MD = Maryland; NH = New Hampshire; PA = Pennsylvania; RI = Rhode Island; WA = Washington; WIOA = Workforce Innovation and Opportunity Act.

- **Sixty-one percent of participants received training** (Exhibit III.6). The share of participants receiving training was highest in Rhode Island and Alaska—95 percent and 84 percent, respectively. As described in Chapter II, Rhode Island and Alaska used a broad recruitment approach, screening individuals at AJCs to see if they were eligible for grant funding. In the states that used a more targeted approach to enrolling grant participants, the share receiving training was substantially lower (as low as 7 percent in Washington). The lower training rate is consistent with the staff reports during site visit interviews that most participants wanted immediate employment.

Exhibit III.6. Share of participants enrolled in a training program, by NHE demonstration grantee



Source: WIPS data through March 31, 2021.

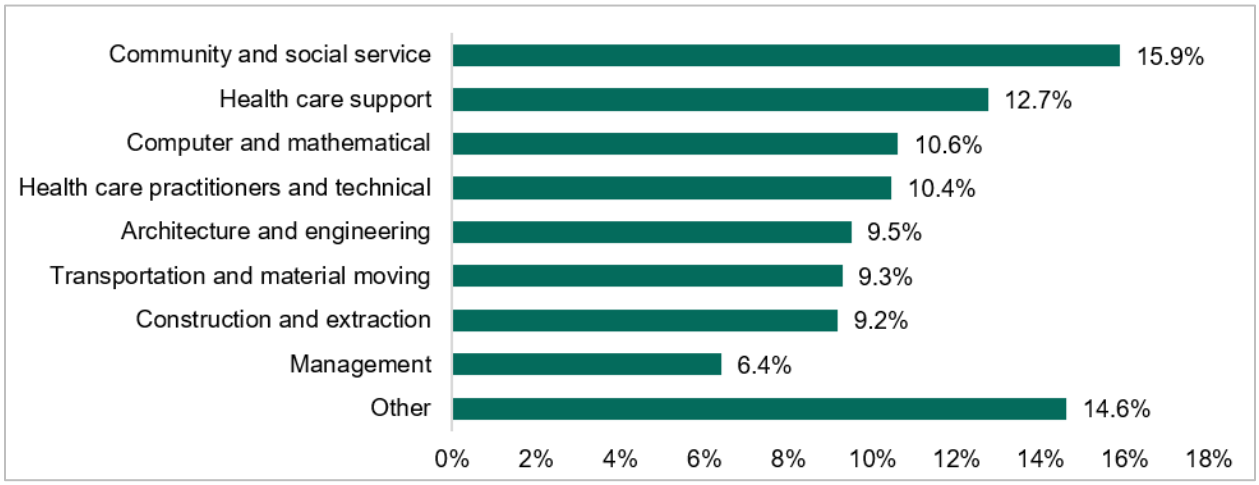
Notes: Sample is 2,985 participants enrolled by NHE demonstration grantees through March 31, 2021.

AK = Alaska; MD = Maryland; NH = New Hampshire; PA = Pennsylvania; RI = Rhode Island; WA = Washington.

- **More than 80 percent of training participants received occupational skills training** (Exhibit III.3). Grantees also reported a small number of individuals in skills upgrading (7 percent), on-the-job training (4 percent), and customized employment (1 percent).
- **Four percent of participants participated in a registered apprenticeship** (Exhibit III.3). Alaska and Rhode Island were the two states that used registered apprenticeships as a grant strategy. Rhode Island's apprenticeships for dual-certified peer recovery specialists and community health workers are discussed in Chapter IV. Alaska uses the NHE grants to continue an effort to support apprenticeships at small health care providers.
- **Four percent of participants were placed in a transitional job** (Exhibit III.3). As discussed above, both Maryland and Washington offered transitional jobs designed specifically for people in recovery to participants through the NHE grant. Although participants were placed with a range of employers, both states focused on placements at CBOs, with the transitional placements lasting 300 to 400 hours.
- **The most common occupational training field was community and social service occupations** (Exhibit III.7). Sixteen percent of trainees enrolled in a program for community and social service occupations. This includes training for occupations such as community health workers, social and human service assistants, and substance abuse and behavioral disorder counselors. The WIPS does not have an occupational code for peer recovery workers, but individuals participating in the peer recovery training described in Chapter IV were likely classified in this category.
- **Health care practitioners and health care support were also common occupational training fields** (Exhibit III.7). In Alaska, 41 percent of occupational skills trainees were enrolled in health care practitioner programs, mostly in programs for registered nursing (RN) (see Appendix Exhibit B.3). The high share of participants training to be RNs may account for the longer average service durations in the state. Pennsylvania reported 13 percent of occupational trainees in the emergency medical technician and paramedic field, but this group may include the incumbent emergency department workers who receive opioid training under the grant (see Chapter V).

- **Aside from social service and health care occupations, participants received training in a wide range of occupations** (Exhibit III.7). Participants also received training in programs for computer and mathematical occupations (11 percent), architecture and engineering occupations (10 percent), construction and extraction (9 percent), and transportation and material moving (9 percent).
- **Among participants who had exited, 48 percent completed a training program and 19 percent received a credential** (Exhibit III.8). The most common credentials were occupational certificates and occupational licensure. In Alaska, a higher share of participants received a credential (55 percent), and some of the participants received associate or bachelor's degrees (24 percent).

Exhibit III.7. Occupational training areas provided by NHE demonstration grantees



Source: WIPS data through March 31, 2021.

Note: Sample is participants enrolled by NHE demonstration grantees through March 31, 2021, who received occupational training. The other occupational category includes all major occupational groups with fewer than 5 percent of participants including business and financial operations; life, physical, and social science; educational instruction and library; arts, design, entertainment, sports, and media; food preparation and serving related; building and grounds cleaning and maintenance; personal care and service; sales and related; office and administrative support; installation, maintenance, and repair; and production. See Appendix Exhibit B.3 for more detail on other occupational training areas.

Exhibit III.8. Training and credentialing outcomes among exiters, by grantee

	All	AK	MD	NH	PA	RI	WA
Completed any training	47.7%	71.4%	32.9%	31.3%	34.6%	81.2%	3.9%
Received a credential	18.5%	54.5%	20.1%	26.1%	39.2%	15.4%	7.0%
Type of credential, if received							
Occupational certificate	59.1%	31.0%	36.4%	95.7%	77.5%	39.9%	97.6%
Occupational licensure	38.6%	66.7%	56.8%	10.9%	12.7%	61.4%	0.0%
AA or AS diploma/degree	2.3%	23.8%	0.0%	0.0%	0.0%	0.0%	0.0%
BA or BS diploma/degree	1.4%	14.3%	0.0%	0.0%	0.0%	0.0%	0.0%
Secondary school diploma/or equivalency	0.9%	0.0%	6.8%	0.0%	0.0%	0.0%	2.4%
Other recognized diploma, degree, or certificate	4.7%	2.4%	0.0%	4.3%	15.7%	0.7%	0.0%

Source: WIPS data through March 31, 2021.

Notes: Sample is 2,309 participants enrolled by NHE demonstration grantees who exited by March 31, 2021.

AK = Alaska; MD = Maryland; NH = New Hampshire; PA = Pennsylvania; RI = Rhode Island; WA = Washington.

IV. Peer Recovery Specialist Careers

Key findings

- Five of six grantees encouraged participants to consider careers as peer recovery specialists and supported training or paid work experience to assist with certification.
- Although limited labor market information is available for this occupation, grantees reported a high demand among people in recovery to enter this field, and participants in focus groups valued that their lived experience with recovery is seen as a strength in this career field.
- In addition to supporting classroom training, grantees supported the hands-on field hours that participants need for certification through on-the-job training and registered apprenticeships.

The majority of NHE demonstration grantees (five out of six) encouraged participants to consider careers as peer recovery specialists and supported either classroom training or on-the-job training and apprenticeships to help participants gain the hands-on hours needed for certification. This strategy accomplished two goals of the NHE demonstration grants: providing employment services to people with opioid use disorder and developing the health care workforce to address the opioid crisis. Peer recovery specialists (also known as peer workers) draw on their personal experience with substance use disorder treatment and recovery to help engage people with substance use disorder in the recovery process and reduce their likelihood of relapse (SAMHSA 2021).The peer workforce is an important and rapidly growing part of the larger behavioral health workforce and can help address provider shortages (Chapman et al. 2018; Gagne et al. 2018; Johansen 2017). A review of the evidence of the effectiveness of peer support for people with substance use disorders found moderate evidence for (1) improved relationships with providers and social supports, (2) reduced rates of relapse, (3) increased satisfaction with overall treatment experience, and (4) increased treatment retention (Reif et al. 2014).

A. Background information on peer recovery specialist careers

Peer workers are broadly defined as people who have been successful in the recovery process and are able to help others going through similar situations (SAMHSA 2021). Peers help people with opioid use disorder to be more likely to achieve sustained, long-term recovery by extending the reach of treatment beyond the clinical setting and modeling ongoing coping and recovery skills. The major types of peer services include (1) providing peer mentoring or coaching, (2) connecting people to recovery resources, (3) facilitating and leading recovery groups, and (4) helping people in recovery build community (SAMHSA 2021; SAMHSA 2009).

Exhibit IV.1. Examples of settings in which peer recovery specialists work

- Hospitals
- Outpatient treatment facilities
- Recovery housing
- Criminal justice
- Law enforcement

Peer workers work in a diverse range of settings, as shown in Exhibit IV.1, and health insurance reimburses for their services in many states (Chapman et al. 2018; Gagne et al. 2018). A Centers for Medicare & Medicaid Services State Medicaid Director letter in 2007 provided guidance to states about reimbursement for peer services, a factor in increasing the use of peer workers throughout the behavioral health treatment system (Chapman et al. 2018; CMS 2007). Peers must complete a state-approved training and certification in order to bill Medicaid (Chapman et al. 2018; Gagne et al. 2018). Although non-

certified peer workers work in many similar settings, achieving state certification improves the employability of this profession, as certification is typically required to bill insurance. Requirements for certification vary by state but typically include completing a minimum number of classroom training hours and hands-on field hours, taking a certification exam, and having a minimum amount of time in recovery oneself. In some cases, the time in recovery is not a state requirement but is preferred by employers hiring for these positions. The number of peer worker positions has grown over time; for example, between 2005 and 2017, the Department of Veterans Affairs created more than 1,200 peer worker positions (Gagne 2018).

There is not a specific occupational code associated with peer specialist positions, which limits the availability of labor market information for this profession. The Bureau of Labor Statistics counts peer recovery specialists under the category of community health workers (Chen 2017). In 2020, the median pay for community health workers was $48,140, and their job outlook was categorized as "much faster than average" growth.[25] As of July 2021, an Internet search of job postings showed that the average national salary was $28,030 for positions listed as "peer support specialists" and $32,114 for "peer specialists."[26] Peer specialists around the country can also gain additional certification to move into higher positions in the recovery field; for example, some peers eventually become licensed alcohol and drug counselors.

B. Grantee approaches to training and other supports for peer workers

Five of the six NHE grantees offered training for peer workers, but the names and certification requirements for peer worker positions vary by state (Exhibit IV.2).

Exhibit IV.2. Names and requirements for peer worker certification in NHE grantee states

State	Position name	Time in recovery needed	Classroom hours needed	Field hours needed	Reimbursable through Medicaid?
Maryland	Certified Peer Recovery Specialist	2 years	46 hours	500 hours	No
New Hampshire	Certified Recovery Support Worker	6 to 12 months	54 hours	500 hours	Yes
Pennsylvania	Certified Recovery Specialist*	18 months	54 hours	No requirement	No
Rhode Island	Peer Recovery Specialist	2 years	46 hours	500 hours	Yes
Washington	Certified Peer Counselor	1 year	40 hours	No requirement	Yes

Source: Interviews with site visit respondents from November 2020 to January 2021.

* With an additional six hours of training, CRSs in Pennsylvania can also become Certified Recovery Family Specialists (CRFS), who support those who are affected by a family member's substance use disorder.

[25] The U.S. Bureau of Labor Statistics occupational outlook for community health workers is available at https://www.bls.gov/ooh/community-and-social-service/health-educators.htm.
[26] This search was conducted using https://www.ziprecruiter.com on July 13, 2021.

In three of the five NHE states supporting training for these positions (New Hampshire, Rhode Island, and Washington), peer services are reimbursable through Medicaid and other insurance (Exhibit IV.2). Washington noted that, at the time of our site visit in December 2020, Medicaid had just begun to cover certified peer counselor services. In Pennsylvania, a mental health position called Certified Peer Specialist is Medicaid reimbursable, but the Certified Recovery Specialist position is not reimbursable through Medicaid.

Grantees supporting training and credentialing for peer workers discussed both a need for these professions in their communities and a high demand among people in recovery wanting to enter these professions. In one state, frontline staff in an AJC noted that employers actively reach out to them looking for candidates to fill these roles. Staff in another state noted that there are usually around 30 positions open in this field across that state at any given time. In addition, a frontline staff member noted that some incumbent workers with lived experience benefit from the peer specialist training even if they do not change jobs, because they bring new skills from the training to their current job and can help make their current workplace more recovery friendly.

Approaches to recruiting and supporting trainees

Grantees took several approaches to supporting program participants seeking to enter peer specialist careers, including supporting the training itself and helping participants gain the hours needed for certification through paid work experience.

- **Grantees recruited participants for peer specialist careers through AJCs and by advertising the training through referral partners.** The five grantees offering training for peer specialists reported two main methods of recruiting participants for these careers. The first was to promote this career path as an opportunity for participants who came to the AJC or other workforce agencies seeking career and training services and who disclosed that they were directly affected by the opioid crisis themselves. These participants were often seeking general career services and did not know this was a career option. AJC staff presented the participants with the option when they conducted a career assessment or provided other career counseling. Participants who entered the program this way spoke highly of being able to leverage their lived experience in a career. One participant said, "I think this [peer recovery specialist training] was amazing and showed me what I wanted to do. I didn't know this was a career. I have in-person experience that a bachelor's degree might not apply to."

  "I have lived experience and the program gives me validation … the certification gives people like us validation that we can then help other peers recover in the same way we did."
  Program participant

  The other recruitment method was to work with partner organizations that could refer people who were specifically interested in this training to grant services. For example, one subgrant leader noted that recovery organizations in the area often identify people seeking training to become peer recovery specialists, so they call the AJC to see whether these candidates would qualify to enroll under the grant. Through partners and subgrantees, grantees also advertised peer specialist trainings directly to people in recovery. For example, one grantee advertised the training at a methadone clinic, and another recruited participants living in a one-year spiritual recovery housing program. Respondents in at least two states reported that this career path is already well known and highly desired among people in recovery. According to one program participant, 500 people are on the waitlist in their state for peer recovery training, and getting a spot in the training can take a year. A subgrant director in this

state noted that one lesson learned from the grant was that they would have put more money into peer worker training.

A local partner providing peer specialist training noted that this certification is particularly helpful for people in recovery with limited work histories who would be considered new entrants in the workforce. Participants appreciated that their lived experience with recovery is considered a strength for this career and eliminates certain challenges, such as explaining gaps in their resumes. As one focus group participant noted, "My resume isn't great, but going through the [peer specialist training] program gives us a chance to shine and show the community what we have. A lot of times you don't get that second chance."

All five of the states offering training for peer workers have requirements for a certain amount of time in recovery (Exhibit IV.2), either as a requirement for state certification or as a requirement of the training provider. Grantees ensured that potential participants seeking to enter peer specialist fields were aware of this requirement and focused on training participants who attested they had achieved the required amount of time in recovery. Although a high school diploma equivalency was required for peer specialist certification in at least one state, no math, reading, or other types of assessments were required.

Four grantees (Maryland, Pennsylvania, Rhode Island, and Washington) directly supported training of new peer recovery specialists through the grant. Across grantees, the time commitments for these classroom-based trainings were 40 to 54 hours, with schedules ranging from full-time for a week to once a week (on Saturdays) for 10 weeks. Trainings were held by training partner agencies including community colleges, four-year colleges, and nonprofit training providers, which were generally able to continue providing training during the COVID pandemic by transitioning to a virtual format. Rhode Island took a unique approach, focusing on cross-training peer recovery specialists and community health workers as well as facilitating dual certification to integrate the strengths of both professions. In particular, dually certified peer recovery specialists benefited from the additional training that community health workers receive on social determinants of health and how to address other medical conditions. Participants in this cross-training said the additional training helped them learn more about the context of how these "upstream" social determinants affect health. Rhode Island also developed an apprenticeship for people seeking dual certification (see Strategy Spotlight 3 for more information).

In addition to supporting training for peer specialists, **three grantees helped program participants gain the hours of field work needed for certification.** For example, New Hampshire helped program participants get on-the-job training placements at recovery centers. Subgrant leadership noted that recovery centers were receptive to taking participants for on-the-job training because the grant was able to pay 50 percent of the trainee's salary during the training period. On-the-job training placements generally lasted for six months at 20 hours per week, allowing participants to meet the 500 hours required for certification while being paid. Without the option for paid work experience, subgrant leaders in this state believed that people who completed the classroom training might have struggled to complete the hours needed for certification, as these hours would have to be obtained on a volunteer basis and participants would have had to work elsewhere at the same time to earn needed income. During on-the-job training, participants worked with a mentor in the organization in which they were placed. Mentors helped identify and fill gaps in individuals' training; for example, some mentors helped train participants in basic office skills and computer skills. A respondent from one recovery center that hosted on-the-job trainings noted, "Our organization has really benefited from [the on-the-job training program] … it allows us to provide additional mentoring and training support for people who are looking to get into the field." A subgrant

director and an employer at a recovery center hosting on-the-job trainings reported that they often hired trainees as permanent employees after they completed training and were certified.

In Maryland, one subgrantee helped participants gain the hours needed for certification through an internship program in which individuals worked in a year-long spiritual recovery program while living there. Rhode Island took another approach to help participants get field hours by developing apprenticeships for dual-certified peer recovery specialists and community health workers (see Strategy Spotlight 3).

At least two grantees provided additional support to help program participants achieve certification, such as providing supportive services to pay for testing fees, criminal background checks, administrative fees, and fingerprinting. One subgrant director noted that the cost for these services is not insignificant, and the grant allowed them to remove these potential barriers to certification for program participants.

Perceived challenges

Although grantee staff and program participants spoke highly, overall, of peer specialist training and other support for these careers, they also encountered a few challenges. These include the following:

Length of time in recovery. At least three respondents working in recovery programs noted that the requirement that people be in recovery for certain amounts of time before they can become peer specialists presented a barrier for people who are ready for employment sooner. For example, in one state, respondents reported that many employers require job candidates to be in recovery for two years before they will hire them as peer specialists. A subgrant director and frontline staff member in this state noted that many people who had gone through an intensive one-year recovery program felt ready after that time and found it difficult to "wait around" to work until they had been in recovery for two years. A referral partner working in a recovery house in another state that requires 18 months in recovery echoed this challenge. At the same time, a peer specialist training provider and several program participants pointed out that the opposite might also be true; they noted that some participants in peer specialist training appeared to be actively using drugs, with one respondent stating that "someone in year three to five in recovery is more likely to be successful than someone barely one and a half years in recovery." The peer specialist training provider noted that the amount of time in recovery needed to be successful in this field varies widely among individuals, and it is difficult to come up with consistent requirements that are not overly exclusive.

- **Need for more supervision and mentorship.** In states in which peer specialist certification does not require a certain number of field hours, subgrant directors and frontline staff noted that retaining peer specialists was challenging. They reported that those newly out of training needed more intensive supervision and on-the-job mentorship and training to be successful in employment. For example, a subgrant director in one state indicated that peer specialists who had completed training and immediately begun working sometimes needed more supervision in establishing boundaries with clients. A local partner in the same state also noted that the peer specialists they worked with were sometimes

Pennsylvania's training for peer specialist supervisors is designed to give supervisors tools for thinking about strengths-based approaches to training and different methods for supervision. As some supervisors do not have lived experience themselves, it is important that they know how to support peer specialists and help with the transition when they start working. The goal of the 12-hour training is to help improve employee onboarding and retention of peer specialists. The training also includes a networking component to allow supervisors to learn best practices from each other. ◢

late to work. To address this challenge, respondents suggested that more apprenticeships or other opportunities for on-the-job learning could be useful. Participants in at least two focus groups echoed this recommendation, suggesting that connecting people to internships following the training would allow them to gain more hands-on experience. As a solution to this challenge, Pennsylvania offered training specifically for supervisors of peer specialists on effectively training and retaining new employees (see callout box).

- Respondents in one state noted that **COVID presented a barrier to participants taking the certification examination**, because the state's licensing board did not allow the exam to be taken in a virtual format. As a result, some participants had to wait a substantial period of time to take the exam, thereby delaying their opportunities for employment.
- Finally, New Hampshire had planned to pay for classroom training for peer specialists through the grant but was unable to do so because **no training providers on the WIOA-eligible training provider list** in their state offered this training. The subgrant director in this state noted that although some organizations that provide such training were interested in going through the process to become eligible, doing so would have taken too long to be useful for this grant. Instead, the subgrantee tried to connect program participants to charitable organizations in the state that offer scholarships for peer specialist training. Once participants completed the training, the subgrantee supported other steps needed for certification, including facilitating on-the-job training and paying certification exam fees and other supportive services.

Strategy Spotlight 3: Registered Apprenticeships for Community Health Workers and Dually Certified Peer Recovery Specialist-Community Health Workers

Implementation context

Apprenticeship RI, an initiative of Building Futures, develops registered apprenticeships in partnership with the Rhode Island Department of Labor.[27] With funds from the NHE demonstration grant, Building Futures, the subgrantee, worked with two partners to develop registered apprenticeship programs for two occupations that could help address the opioid crisis: Community health workers (CHWs) and dually certified peer recovery specialist (PRS)–CHWs.

Program staff from Apprenticeship RI noted the great need for CHWs to work directly with people with opioid use disorder. CHWs' work can vary substantially: for example, some focus on helping people navigate insurance coverage, while others focus on addressing the social determinants of health, such as accessing affordable housing and healthy food. Through the grant, Apprenticeship RI sought to standardize training and increase the pipeline of qualified CHWs and PRS-CHWs using registered apprenticeships.

Key intervention components

Apprenticeship RI provided grant funds for the development of two registered apprenticeship programs:

- Rhode Island Parent Information Network– the largest employer of CHWs in the state created the state's first CHW registered apprenticeship program. The 18-month registered apprenticeship enables CHWs to complete the hours needed for certification while earning income and receiving on-the-job training through RIPIN, the employer of all apprentices in this program. In addition to gaining the field hours needed for certification, this time on the job helps CHWs develop a portfolio documenting their work, which is also a certification requirement. The apprenticeship lasts 2,000 – 3,000 hours, and 43 apprentices have participated in the program as of September 2021.
- Parent Support Network developed the requirements for the new PRS-CHW apprenticeship. The 2,000-hour apprenticeship includes 50 hours of classroom training for people already trained as PRSs, with the remainder as structured on-the-job learning at Parent Support Network or one of seven local community-based organizations that serve as employer partners. Supervisors at the organizations structure time on the job to facilitate learning, with technical assistance from Apprenticeship RI. Apprenticeship RI worked with the RI Department of Health to ensure the PRS-CHW apprenticeship aligns with the RI Certification Board requirements.

Potential elements for success

Both partners have become champions of the registered apprenticeship model and planned to continue their apprenticeship programs when grant funding ends. Interview respondents at Apprenticeship RI attributed this success to several factors:

- **Starting with incumbent workers** enabled the partners to introduce employers to the apprenticeship model and first train employees who were determined to be in need of additional competencies. The partners then encouraged employers to expand the program to hire new apprentices not previously employed with their agency.
- **Buy-in and commitment of partners.** Apprenticeship RI noted both partners have embraced the apprenticeship model and champion its effectiveness as a workforce development strategy. Nine

[27] Over the past five years, Building Futures, using its experience developing registered apprenticeships in the construction industry, has expanded into other sectors, including health care, information technology, advanced manufacturing, marine trades, and agriculture/plant-based industries. For more information, please see https://www.bfri.org/.

employers now sponsor apprenticeships, including RIPIN and Parent Support Network, and the partners continue to build relationships with new employers.

- Two respondents cited **the apprenticeship for dual PRS-CHWs** as successful because the two careers are highly interrelated and participants valued this joint training. Although skill sets for the two professions overlap to some extent, required trainings for them teach complementary skills. The program started with PRSs who wanted to become certified as CHWs; it has now expanded to include CHWs with their own lived experience with substance use disorder who want to become certified as PRSs. Parent Support Network had enrolled 53 dual PRS-CHW apprentices across different cohorts as of September 2021, and 87 percent had completed the apprenticeship or were still actively enrolled, which was a higher retention rate than anticipated.

"I often encourage new employers to start with incumbent workers to beta test the apprenticeship model. Then they'll likely want to expand it for new incoming employees."

Interview respondent

Implementation challenges and strategies

Respondents noted that, in sectors outside of construction, employers generally are unfamiliar with the registered apprenticeship model. In the first year of the NHE demonstration grant, Apprenticeship RI focused on providing technical assistance to employers to develop and implement registered apprenticeship. The success of the first cohort of apprentices provided a launch pad for recruiting other employers into the program, as employers became more familiar with the apprenticeship model. One interview respondent stated, "After that first cohort, it paved the way for the rest of the grant."

V. Training Incumbent Workers to Better Address the Opioid Crisis

Key findings

- Incumbent worker training offered through the NHE demonstration grants differed from typical DOL-funded incumbent worker training because it focused on building workforce capacity to serve people with opioid use disorder, rather than wage gains or advancement for the individuals trained.
- Alaska and Pennsylvania created trainings for emergency department workers on better serving people with opioid use disorder, which included topics such as providing care in an empathetic way and motivational interviewing.
- Alaska and Pennsylvania also trained other professionals including law enforcement and employees of human service organizations on better serving people with opioid use disorder.

The NHE demonstration grants sought to encourage local development of professions that could address or prevent opioid problems in communities. As part of this effort to build the capacity of the local workforce, NHE demonstration grantees had the authority to fund training for incumbent workers. Typically under WIOA, DOL-funded incumbent worker training is designed to ensure that current employees of a company can acquire the skills necessary to advance within the company or to avert a layoff. Incumbent worker training under the NHE demonstration grants, however, focused on addressing a larger social issue—the opioid crisis—by building the capacity of the health care workforce and other workers who interface with people directly or indirectly affected by opioid use disorder.

Alaska and Pennsylvania included incumbent worker training as a focus of their NHE demonstration grants. Incumbent workers who received training were expected to directly benefit from new skills and an enhanced capacity to provide informed care. This is different from traditional incumbent worker training, however; people affected by opioid use with whom these incumbent workers interact were intended as the primary beneficiary of the training through the form of improved care. When workers receive training in how to respond to immediate opioid use disorder-induced health crises (such as overdose) and less acute but nonetheless critical issues (such as empathic engagement and avoiding burnout), people affected by opioid use disorder will also benefit, and the capacity of systems to respond appropriately grows.

In this section, we explore two approaches to incumbent worker training: (1) opioid-specific training for incumbent health care workers and (2) opioid-specific training offered to non-health care workers.

A. Opioid-specific trainings for incumbent health care workers in emergency departments

Alaska and Pennsylvania created trainings for emergency department workers on better serving people with opioid use disorder. In Alaska, grantee partner Alaska State Hospital and Nursing Home Association (ASHNHA) created an emergency department (ED) training plan for ED nurses and staff on addressing the opioid crisis and how to avoid staff burnout. Respondents in Alaska noted that the grant presented an opportunity to address a need identified previously by ASHNHA members for staff training on strategies to effectively work with people with substance use disorders, as well as how to avoid "compassion fatigue." In Pennsylvania, subgrantee Philadelphia Works partnered with Jefferson University Hospital (Jefferson), which runs several EDs at hospitals throughout Philadelphia, to train their incumbent health care workers on the opioid crisis. Together, they developed and implemented a series of educational

modules on opioid sensitivity to help ED staff better support and empathize with patients with opioid use disorder. Jefferson sought to improve health care for all people with opioid use disorder, including those who came to the ED for other reasons, and wanted to ensure that all ED workers were administering care in a trauma-sensitive way—meaning that they recognize the presence of trauma and acknowledge the role that trauma may play in a patient's life.

Key features of these trainings included the following:

- **Broad curriculum content.** In designing training for ED staff, the two grantees covered topics that included understanding opioid addiction; approaches to treating opioid use disorder, including harm reduction, medication-assisted treatment, and coordinating care across family and health care systems; preventing burnout among health care staff; and providing care in an empathetic way. Exhibit V.1 highlights key topics in Alaska's training. A respondent from ASHNHA reported that they felt the training would have a greater impact if the focus was expanded to include addiction to substances other than opioids and a broader application of trauma-informed care. For example, motivational interviewing is a technique for supporting people addicted to substances as they work toward recovery through supportive, nonjudgmental conversation. In addition, in order to retain skilled staff and prevent staff turnover due to burnout, ASHNHA focused on staff self-care. Jefferson's training focused on providing empathy-driven and trauma-sensitive care, and also included topics such as how addiction affects the brain and how to provide "warm handoffs" (a process of transferring care between providers with the patient present).[28]

Exhibit V.1. Key topics in Alaska's ED training curriculum

- Harm reduction 101 (online)
- Compassion fatigue and preventing burnout (online)
- Alternative pain treatment modalities for people with substance use disorder (in-person)
- Using motivational interviewing tools to support substance use disorder treatment (in-person)

- **Flexible design including online components for busy ED staff.** Alaska offered two in-person trainings at Providence Alaska Medical Center in Anchorage and two online webinars (60 to 90 minutes each). ASHNHA, a statewide organization, invited ED staff from various member hospitals to participate. The four training events were presented as a unified program. Outreach materials encouraged participants to attend all of the training events, but participants could also sign up for individual training events. More than 100 participants completed a least one of the four trainings, which were held in October and November 2019. (Additional trainings scheduled for 2020 were postponed because once the COVID-19 pandemic began, ED staff did not have the time or availability to continue with trainings.) Although all of the training content could have been provided virtually, ASHNHA decided that the motivational interviewing training should be done in person to allow training participants to practice the techniques face to face with each other. In Pennsylvania, Jefferson designed a training that is done completely online, to reach busy ED staff; it included self-paced modules, as the staff do not have much available time. The online training included six modules that staff could complete whenever they had time. Together, the modules were designed to take no more than 90 minutes, but because participation was self-paced, individual participants could spend more time if they wanted to. More than 400 people had completed the training at the time of our virtual site visit in November 2020.

[28] For more information about warm handoffs, please see https://www.ahrq.gov/patient-safety/reports/engage/interventions/warmhandoff.html.

- **Inclusion of nonclinical staff.** Jefferson decided to focus on the department as a whole, not just clinicians, because people with opioid use disorder who enter the ED interact with various types of staff members. The hospital wanted to ensure that all staff who interact with patients had access to training on trauma-informed approaches for working with people with opioid use disorder. As a result, the training was offered to all staff working in the EDs, including both clinical and nonclinical ED staff such as intake personnel and security guards. Five of the six modules that are part of Jefferson's online training on a trauma-sensitive approach to caring for patient with opioid use disorder were for staff with any role at the ED. The sixth module was specifically for clinical staff; this module focused on how addiction affects the brain, and it could be taken for continuing medical education credits. The five training modules for all ED staff types included different interactive scenarios that were customized based on trainee responses to questions about their roles and responsibilities (for example, scenarios would be different if the participant indicated they were a security guard or a nurse). In Alaska, the trainings were offered to any staff working in EDs, and the types of staff attending varied based on the topic of each session. For example, the motivational interviewing training included staff in a range of roles such as nurses, social workers, and counselors.
- **Collaborative design process.** In Pennsylvania, Jefferson convened a group of subject matter experts that spent six months working together, as well as with a digital education group, to collaboratively design the training. Before creating the training, the team sent a survey to ED employees to obtain their perceptions of patients with opioid use disorder. The Pennsylvania team reported that they felt strongly about the value of working collaboratively with a diverse group with a range of expertise, including experts on trauma-centered and empathy-driven care from the College of Nursing, as well as physicians focused on medication-assisted treatment for opioid use disorder and emergency medicine. The training also incorporated perspectives of people with lived experience with opioid use disorder, including via audio clips they narrated. The audio clips, in particular, focused on how negative interactions that people with opioid use disorder experienced in the ED stayed with them and dissuaded them from seeking needed ED care in the future. Alaska developed its training topics based on the needs that ASHNHA members had identified at the association's annual meeting.

The primary challenge that the subgrantee in Pennsylvania faced was related to the grant's data requirements, as the grantee considered hospital staff taking these trainings to be grant participants. The grant required the collection of personally identifiable information from training participants, such as their Social Security number. This was a challenge because hospital staff were not expecting to provide that information when taking an online training, and Jefferson needed to work with its human resource and legal departments to develop a process for learners to provide consent to share their personally identifiable information before taking the training, which subgrantee administrators indicated was burdensome. This reporting issue is a common concern for incumbent worker training (Rowe et al. 2012). A subgrant respondent also noted that grant performance measures such as employment placement and increased earnings were not applicable to training participants because they were already employed in the hospitals and the trainings were not designed to increase their income. Alaska used grant resources to develop and implement the training but did not officially enroll the attendees as grant participants that required outcomes tracking.

After the end of the grant period, Jefferson's online educational modules will still be available for ED staff, and the hospital has shared the modules with hospitals in other areas of the state that were interested in implementing a similar training.

B. Opioid-specific trainings offered to other incumbent workers

In addition to training incumbent health care workers to better address the opioid crisis, Alaska and Pennsylvania provided opioid-specific training for incumbent workers in various other fields that may interact with individuals with opioid use disorder. For example, law enforcement officials are likely to respond to people experiencing overdose and may benefit from training on how to respond appropriately (Wagner 2016). Other professionals in human service organizations are also likely to interact with individuals in recovery and may benefit from training to better serve these individuals and connect them to treatment providers, if needed.

Examples of these trainings included the following:

Training for law enforcement. Alaska offered training to increase awareness of substance use disorder to members of a community coalition on substance use, which included the Kodiak Police Department and other community members. Alaska partnered with the Hazeldon Betty Ford Foundation to implement training for the Kodiak Police Department, other first responders, and other community organizations and individuals. The training was envisioned as a two-part series, but the second training was postponed due to COVID-19, and it had not been rescheduled as of December 2020. The first part of the training series was a full-day in-person training addressing stigma associated with substance use and promoting a supportive response instead of vilification of the user. The training had an anti-discrimination focus and included information on the cycle of care and recovery. In Kodiak, attendees of the day-long training included employees of the Kodiak Police Department; participants from the public workforce system, various faith-based organizations, behavioral health organizations, and the offices of the district attorney and the defense attorney; and community members and people in recovery. In total, 92 people attended the first training, including 13 police officers. After the first training, the community coalition on substance use in Kodiak developed an action plan that focused on developing a culture of recovery in the law enforcement, first responder, and public assistance communities. The second training was designed as a three-day training on the principles of care related to trauma, particularly with respect to opioid addiction, and on creating a recovery-oriented organizational culture. Exhibit V.2 provides an overview of the training as planned. Planned attendees for the second training included people in law enforcement, corrections, and community-based organizations. Day three was intended to engage a subset of the cohort and focus primarily on organizational leaders and implementing organizational change.

Exhibit V.2. Alaska's planned incumbent worker training in Kodiak

- **Day 1.** Principles of trauma and the impact of traumatic events leading to opioid use and opioid use disorder
- **Day 2.** Trauma within corrections and law enforcement settings: Skills and tools for health and wellness on the job
- **Day 3.** Organizational change: How the opioid epidemic impacts organizations; concepts and principles of trauma-informed organizational change in response to the opioid epidemic ◢

Professional development for human service workers. In Pennsylvania, Philadelphia Works partnered with the District 1199c Training and Upgrading Fund (District 1199c) to offer training to human service workers to better support the recovery of people with opioid use disorder. The Opioid Crisis Training was designed with a broad focus on professional development and how to address the opioid crisis. It focused on major concepts in opioid use disorder and its treatment, such as the stages of recovery and the process of providing "warm handoffs" to new health care providers (Exhibit V.3). The 25-hour training was delivered through weekly 2.5-hour sessions over 11 weeks. Training was hosted either on-site at an employer's workplace or at the District 1199c's training center in Philadelphia. A primary aspect of the training is that all the trainers were also in recovery, so they could share their lived experience to enhance the training content. In Philadelphia, participants included incumbent workers from a variety of employers working in recovery-related fields. These employers included a health system, multiple recovery houses, a homeless shelter, and organizations providing outpatient services. District 1199c also hosted training for three community-based cohorts that included diverse participants, including case managers from behavioral health sites, college students, and teacher's aides. The primary obstacle was scheduling the training at a time when all staff would be able to attend, as the trainings were scheduled during the work day. During the COVID-19 pandemic, District 1199c continued to offer the training via Zoom; an employer respondent offered positive feedback about this format and noted that it included interactive components such as quizzes and polls.

Exhibit V.3. Sample topics from Pennsylvania's Opioid Crisis Training

- Outreach and engagement
- Withdrawal management
- Naloxone overdose and rescue
- Harm reduction
- Understanding co-occurring disorders
- Warm handoff between emergency departments and treatment providers
- Motivational interviewing

Trainings for smaller businesses. Alaska offered incumbent worker training to small to medium-size businesses (with 50 or fewer employees) through the grant. These businesses were able to select their own training provider and the trainings were focused on various topics such as recognizing behavioral issues that might indicate an opioid use disorder and helping staff prevent burnout. Alaska used the same process for incumbent worker training funded through the NHE demonstration grant as the state uses for incumbent worker training paid for by WIOIA funds.[29]

Planned training for teachers. Alaska had also planned to train teachers in identifying potential opioid issues and addressing them with students, but due largely to the COVID-19 pandemic, the training was never offered.

Grantees planned to sustain some of these efforts after the end of the grant period. Alaska plans to sustain its partnerships and incumbent worker training on opioid use disorder and trauma-informed intervention through WIOIA Title I funding after the grant ends. Moreover, the design of the second training developed for the Kodiak Police Department was shared as a best practice with the Nome police department, which expressed interest in it. In Pennsylvania, state grant leadership noted that they would like to sustain opioid crisis training, although this depends on securing another funding source.

[29] For more information about Alaska's incumbent worker training program, please see https://labor.alaska.gov/dets/iwtp.htm.

This page has been left blank for double-sided copying.

VI. Working with Employers

Key findings

- NHE demonstration grantees developed models to provide technical assistance to help employers support employees with opioid use disorder and signal their willingness to employ individuals in recovery.
- One grantee developed sector-specific trainings for employers in the construction industry, a sector highly affected by the opioid crisis.

Employers can play multiple roles in preventing the negative effects of opioid misuse and helping employees recover from opioid use disorder (Vine et al. 2020). Through their ongoing interactions with their employees, employers have frequent opportunities to offer resources, benefits, and supports for recovery; offer access to work, which provides employees in recovery with structure and motivation; and provide important resources and benefits. However, employers may feel ill prepared to adequately support employees in recovery; a study found that only 17 percent of employers reported feeling extremely well prepared to deal with the opioid crisis, and 75 percent felt that their workplace had been impacted by opioid-related issues (National Safety Council 2019). Although employer-focused strategies were not an official goal of the NHE demonstration grants, three grantees developed strategies in this area as a key method of addressing the workforce-related effects of the opioid crisis. These included providing education on strategies employers could use to create a supportive workplace that gives employees in recovery the resources to remain healthy and employed, as well as education on other topics such as human resource policies.

The strategies discussed in this section—(1) supporting recovery-friendly workplaces and (2) sector-specific trainings for employers in the construction sector—were designed to address employer needs. Each strategy involved seeking input from employers to ensure that the offerings would be relevant and helpful to them.

A. Supporting recovery-friendly workplaces

Two of the six NHE demonstration grantees focused their efforts on promoting designated Recovery Friendly Workplace initiatives in their states. New Hampshire had started the state's Governor's Recovery Friendly Workplace initiative before it was awarded the NHE grant, and it used grant funds to supplement the efforts and partner with this statewide initiative.[30] Rhode Island launched its Recovery Friendly Workplace initiative using NHE grant funds, although the initiative later transitioned to another grant funding source.[31] Rhode Island leveraged the knowledge, experience, and materials from New Hampshire, whose initiative launched first.[32]

Launched by the governor of New Hampshire in 2018, Recovery Friendly Workplace has received nationwide attention as a promising model and has now been replicated in other states (Brandeis Opioid

[30] For more information about New Hampshire's Recovery Friendly Workplace initiative, please see https://www.recoveryfriendlyworkplace.com/.
[31] For more information about Rhode Island's Recovery Friendly Workplace initiative, please see https://recoveryfriendlyri.com/.
[32] Although Alaska did not have a recovery-friendly workplace initiative, the grantee shared the following resource with employers: Addiction in the Workplace.

Resource Connector 2020). The initiative aims to help employers (1) foster a safe, recovery-friendly environment; (2) engage employees in addiction and behavioral health education and prevention; (3) retain healthy and productive employees; and (4) promote prevention and recovery in their local communities. The initiative recognizes that substance misuse cost New Hampshire over $2.36 billion per year, with the majority of that cost incurred by employers due to lowered productivity and absenteeism. The initiative aims to help participating employers achieve outcomes such as increased productivity, healthier employees, and lower absenteeism and turnover (NH Governor's Recovery Friendly Workplace Initiative 2020).

State partners in New Hampshire and Rhode Island described the process through which their Recovery Friendly Workplace initiatives operate, although this initiative was not funded by the NHE demonstration grant in New Hampshire. In both states, the Recovery Friendly Workplace initiatives reach out to employers about the benefits of receiving a designation as a Recovery Friendly Workplace. Interested employers submit an electronic letter of intent to their state via the initiative websites. Staff then contact them to conduct an orientation, during which the employers learn more about the initiative and the initiative learns from the employers about their needs. Employers who want to proceed toward the designation make a declaration to their own employees about their commitment and intention to become a designated Recovery Friendly Workplace. They then work with the initiative to complete the necessary requirements over the next year. In both states, employers need to meet the same set of requirements to be designated as recovery friendly (Exhibit VI.1). At the same time, the leader of one state's Recovery Friendly Workplace initiative noted that the initiative works one on one with employers to help them set goals and support them in accomplishing their goals, rather than simply serving as a "regulatory body."

Exhibit VI.1. Requirements for becoming a Recovery Friendly Workplace

- Provide employees with information and resources to promote health, well-being, and recovery for themselves and their family members.
- Establish connections with local recovery support organizations as a resource for employees.
- Ensure supervisors receive education on existing alcohol, tobacco, and other drug policies upon hiring and on an annual basis thereafter.
- Ensure supervisors and employees receive annual training and education on substance misuse, behavioral health, and addiction.

Sources: https://www.recoveryfriendlyworkplace.com/join-us; https://recoveryfriendlyri.com/join-us/.

New Hampshire used NHE demonstration grant funding to develop materials to support the state's existing Recovery Friendly Workplace initiative. The state was using other funding to support five nonprofit organizations—which included recovery organizations and other community organizations with a behavioral health focus—in delivering Recovery Friendly Workplace programming to businesses. Recognizing a need to develop statewide consistency in how these nonprofits were supporting businesses to become recovery friendly, the state used NHE demonstration grant funds to develop training materials, grouped into four training modules, that the nonprofits could use to provide training to employers (Exhibit VI.2). Each module had subcategories, including trainer manuals and participant handouts. The NHE demonstration grant also funded a monthly community of practice for the nonprofit organizations that were providing technical assistance to businesses, which allowed them to share their work with each other and discuss any adaptations they were making. A state partner respondent indicated that the level of support that the nonprofit organizations provided to employers varied widely based on their needs.

Examples of services that the nonprofit organizations provided to businesses included recruitment support, employee training, and a 24-hour hotline.

Exhibit VI.2. New Hampshire's Recovery Friendly training curriculum for employers

New Hampshire used NHE grant funding to develop four training modules that nonprofit partners used to support employers working with the Recovery Friendly Workplace initiative. The nonprofits did not deliver each of these modules to every employer; rather, they customized the training based on the employer's needs. The modules addressed the following:

- Substance use disorder
- Recovery and workplace wellness
- Community resources for the recovery-friendly workplace
- Guidelines, policies, and programs for the employer to consider ◢

Finally, New Hampshire used NHE demonstration grant funds to develop marketing materials that included a video, poster, brochure, flyer, and social media graphics to educate employers about the resources available to support them, such as the NHE grant and 211 (the United Way's phone number to access essential community resources). A respondent at the organization that developed the materials thought that many businesses did not initially believe that they needed these services, but the outreach campaign helped them realize how much they could benefit. For example, the same respondent reported that businesses particularly appreciated a video that captured two employers talking about the impact of recovery-friendly services on their businesses.

Work with employers funded under the NHE demonstration grant produced several reported successes:

- **Collaborating between grantees.** New Hampshire welcomed outreach from Rhode Island about how to start a Recovery Friendly Workplace initiative. Because New Hampshire intended its program to be disseminated and implemented in other states, it gave Rhode Island its materials to tailor for its state. This allowed Rhode Island to jumpstart its initiative, implementing it more quickly and with fewer resources.
- **Building the list of Recovery Friendly Workplaces.** By end of 2020, 44 employers in Rhode Island submitted a letter of interest, including a health system that is the state's largest employer, and 25 achieved official designation. As a result, 5 percent of employees in the state were working in recovery-friendly workplaces. Though not funded through the grant, New Hampshire experienced similar success, designating 279 workplaces, which together employed over 70,000 people, as recovery friendly. The lists of Recovery Friendly Workplaces are available to the public on the initiatives' websites, enabling people in recovery to use them in their job searches.
- **Creating connections among employers.** New Hampshire reported that employers in the Recovery Friendly Workplace initiative reach out to each other for support. A respondent working with the initiative considered this a substantial cultural shift that had occurred only in the last few years.
- **Developing recognizable branding.** Employers who have signed onto the initiative put a sticker in their window with the Recovery Friendly Workplace initiative logo. In Rhode Island, a respondent working on the initiative reported that the community has started to recognize that employers with this sticker are recovery friendly.

- **Increasing naloxone in the community.** The University of Rhode Island created the NaloxBox, which is placed on a wall in the workplace and provides naloxone and instructions for how to appropriately respond to an overdose.[33] This not only equips workplaces with what they need to reverse an overdose but also fights stigma and normalizes conversations in the workplace about recovery. The Rhode Island Recovery Friendly Workplace initiative provided the NaloxBox to companies participating in the initiative.

Grantees reported a few challenges in connection to supporting Recovery Friendly Workplace initiatives. The primary implementation challenge that Recovery Friendly Workplace initiatives reported facing was overcoming the stigma of addiction among employers. One respondent leading a Recovery Friendly Workplace initiative reported that some employers did not want to participate or have their workplace publicly recognized as recovery friendly out of concern that they could lose business if clientele knew they hired people in recovery. Another reported challenge was that consistent and sufficient funding of this effort proved difficult, particularly in Rhode Island, which only had one employee working on the initiative. Rhode Island's initiative was originally funded through the NHE demonstration grant but was being supported by another grant at the time of our interviews in January 2021, and the state was seeking a permanent funding source. The COVID-19 pandemic also slowed down grantees' efforts. Rhode Island's initiative launched in February 2020, so most of the work with employers had been conducted virtually. Although the Recovery Friendly Workplace initiatives adapted much of their work to a virtual environment, respondents indicated that, in general, employers had less time and energy to engage with the initiatives as they were adapting to changing regulations in their workplaces because of the pandemic.

Pennsylvania took a different approach to promoting recovery-friendly workplaces. The state used the NHE demonstration grant to develop a series of learning sessions for employers seeking to develop a recovery-friendly environment, using the Project Extension for Community Healthcare Outcomes (ECHO) model. The ECHO model involves virtual learning sessions in which participants discuss real-world cases with experts, who provide input and advice. Pennsylvania used this model to connect interested employers with an interdisciplinary expert team that could increase employers' understanding of recovery from opioid use disorder and answer questions about potential human resource issues that may arise when employing people in recovery. Employers from throughout the state attended these virtual sessions, which were held once a week for a 10-week period. For more information about this intervention, see Strategy Spotlight 4.

[33] For more information, see https://naloxbox.org/. Accessed July 29, 2021.

Strategy Spotlight 4: Supporting employers using the Project Extension for Community Healthcare Outcomes (ECHO) model

Employers seeking to have recovery-friendly workplaces might have questions about how to better support their employees who are recovering from a substance-use disorder. Small- and medium-sized employers, in particular, might not have sufficient capacity or expertise in human resources to address potential issues that can arise. This strategy spotlight highlights an innovative effort, funded through a National Health Emergency (NHE) Dislocated Worker Demonstration Grant to Address the Opioid Crisis, to provide Pennsylvania employers with free expert advice on how to address potential issues and support their employees in recovery.

Implementation context

For the NHE grant, the Pennsylvania Department of Labor and Industry (L&I) partnered with the Pennsylvania State College of Medicine (Penn State) to create a Project Extension for Community Healthcare Outcomes (ECHO) series for employers. The ECHO model, which originated in the medical field, provides virtual clinics led by expert specialist teams to discuss real-world health cases with community medical providers in underserved areas and work together to develop solutions.[34]

Key intervention components

Using this model, Pennsylvania created a Project ECHO series through which an interdisciplinary expert team provided "employers and all levels of staff working with employees in an administrative capacity with the knowledge, resources and best practices to support employees in recovery." Typically, each virtual session included a team of experts—a human resources expert, a representative from a drug court, an employment lawyer, an addiction specialist social worker, and an addiction specialist physician—and began with an expert-led presentation on a topic of interest. This presentation was followed by a real-world case study that had been volunteered by one of the employers and a group discussion of the case.

Examples of Project ECHO sessions for employers

1. Medical marijuana in the workplace
2. Employers' concerns with medication-assisted treatment
3. Drug screens

Organizing the sessions. L&I and the Penn State Project ECHO coordinator, who manages other Project ECHO series, worked together to identify (1) the list of employers to engage, (2) the topics of interest and the expertise needed to address those topics, and (3) the timing of the sessions. The coordinator then organized the sessions, including securing presenters and marketing the session to employers. The series occurred over Zoom for 10 weeks, with sessions offered at two different times each week to maximize the participation of employers from across the state. They aimed to limit the size of each session to 15 to 20 participants to encourage discussion.

Reaching out to employers. Both partners were involved in reaching out to employers. L&I provided a list of employers for Penn State to contact about the series, and advertised the program via its electronic mailing list. The Penn State marketing team created a flyer with information about the series and emailed it to the list of potential participants with a registration link. Registration remained open for the entire series, enabling participants to register at any time and not obligating them to attend the full series. Depending on the level of response for any given session, the

> **"…one of the things that project ECHO [does] … is … take a place with a lot of resources, for example like an academic institution with a wealth of experts, and [reach] out to other smaller groups that don't always have access to all of those resources."**
>
> ***Interview respondent***

[34] University of New Mexico School of medicine. "Project ECHO." Available at https://hsc.unm.edu/echo/.

Project ECHO marketing team conducted additional email outreach to the list of employers to increase participation, and, before each session, the Project ECHO coordinator sent an email reminder to registrants. Interview respondents estimated that about 20 employers participated each week, with many of the same employers participating each week.

Obtaining feedback. Following the session, the coordinator circulated a feedback survey and any materials presenters wished to share. Everyone who registered for the series received the materials, including those who had not attended the specific session to which the materials pertained. The feedback survey results indicated that employers appreciated gaining more insight into the experiences and needs of people in recovery, increasing their understanding of the topics covered, and developing a sense of camaraderie with other employers seeking to be recovery friendly. Employers received a certificate of completion after they completed the evaluation for each session.

Potential elements for success

Staff from L&I and Project ECHO perceived four factors as contributing to the success of the Project ECHO series for employers:

1. **Strong partnership between L&I and the Project ECHO team.** Each partner brought something to the partnership. L&I understood the needs of its intended audience, the employers to engage, and potential presenters from the workforce field. The Project ECHO team was experienced in conducting Project ECHO series and offered medical expertise.
2. **Recruiting the target population through multiple methods.** Project ECHO staff reached out to the employers L&I identified. L&I also sent emails via its electronic mailing list to increase awareness of the program.
3. **Identifying highly relevant and timely topics of discussion.** The Project ECHO coordinator sought real-world cases and hypothetical situations that would lend themselves well to case study discussions among the panel of experts and attendees. The case studies allowed for rich discussion and gave experts the opportunity to answer participants' questions.

> **"I think the group of experts really advocates for the employees and really cares about them.… [They have] the heart to educate everyone, and I think that the participants have been really receptive to that and have been really wanting to just be better for the people in their organization.**
>
> ***Interview respondent***

4. **Bringing together experts from different fields to support employers.** L&I and Project ECHO staff believed participants benefited from hearing from experts with wide-ranging knowledge about how to handle situations the participants had experienced or might experience in the future. Project ECHO staff perceived that this built participants' capacity to navigate potential issues.

Implementation challenges and strategies

Project ECHO staff reported the biggest challenge in adapting a Project ECHO for employers was in identifying topics and real-world cases to discuss. They perceived that participants felt intimidated suggesting case studies and presenting them to the group. Staff said sometimes participants also were concerned about privacy for the employee whose case they wanted to discuss, especially if their business was small and it could be possible to identify the individual. To overcome this challenge which Penn State had experienced in other series, the Project ECHO coordinator, rather than the employer, offered to present the case study.

L&I reported wanting to continue operating the Project ECHO session for employers after the NHE grant period, but that it would depend on its ability to secure funding. The state said it sought additional sources of funding, including having the local workforce boards look for funding and possibly using Workforce Innovation and Opportunity Act funding.

B. Opioid education training for construction sector employers

In Rhode Island, one subgrantee, Building Futures, developed an opioid education curriculum for the construction sector, which has been highly affected by the opioid epidemic. Building Futures staff noted that according to the Rhode Island Department of Health, nearly one in five overdose deaths in the state occur among workers in the construction sector.[35] The opioid education curriculum focuses on the high incidence of opioid use disorder within the construction sector, how to identify co-workers who need help, and how to overcome barriers to reporting, such as "not wanting to report your buddy" who may have an issue.

Building Futures led the development of this curriculum in collaboration with the Rhode Island Department of Health and the Department of Behavioral Healthcare, Developmental Disabilities & Hospitals. They also engaged with licensed peer recovery specialists and officials from the building trades to solicit honest feedback about what would work and what could be modified to better help the community served. The curriculum was designed to be delivered in two 90-minute training sessions. The subgrantee piloted the curriculum during its existing pre-apprenticeship training program for construction workers. In addition to the training curriculum, Building Futures developed resources including Toolbox Talks, which are short training segments that could be delivered during a work break, as a way to sustain the engagement beyond a one-time training (Exhibit VI.3).[36]

"There used to be stigma regarding substance use or about Narcan being on [union] sites. Now we are talking about suicide prevention on a job site, so the conversation is much different now. Now the unions are much less gun-shy about candidates that have substance use issues."

Subgrantee staff

Exhibit VI.3. Toolbox Talks topics

- Prevention: Stress Defense
- Prevention: Address Pain
- Help a Friend Find Treatment
- Support Recovery
- Narcan & Rescue Training

As of January 2021, Building Futures had trained more than 100 participants, including construction union leaders, stewards (people designated as union trainers on particular job sites), workers, and pre-apprentices. Subgrantee staff reported that employers and unions in the construction sector are now more open to hiring candidates with substance use disorder. The organization has used a train-the-trainer model to train people in the construction industry to deliver the opioid education training to their peers. Focus group participants reported that they found the opioid education training useful. One participant in the pre-apprenticeship training said the opioid education training "was one of the parts of the class that stuck in my head." Another said, "That blew my mind that they [offered] that [training]." Due to the success in the construction industry and requests from other sectors, Building Future has integrated the content of the curriculum into its construction apprenticeship program and has adapted and expanded the training to other sectors such as health care, including its apprenticeship program for community health workers.

[35] These and other statistics on overdose deaths in Rhode Island are available at https://preventoverdoseri.org/wp-content/uploads/2019/10/Master-TF-August_Final.pdf.

[36] These Toolbox Talks and other opioid education materials from Building Futures are available at https://www.bfri.org/opioidresponse/.

This page has been left blank for double-sided copying.

VII. Overall Lessons Learned and Discussion

The NHE demonstration grant implementation study findings demonstrate the accomplishments and challenges that grantees faced in implementing these grants. Through the course of the demonstration and despite the challenges of the COVID-19 pandemic, six states provided employment services for people affected by the opioid crisis, supported people in recovery to become peer workers, trained incumbent workers to better address the opioid crisis, and worked with employers to create recovery-friendly workplaces. In this chapter, we summarize our key findings and considerations for future study.

- **Grantees provided employment services to almost 3,000 participants and made other investments to support individuals in recovery.** All the participants received individualized career services, and 61 percent enrolled in training. Five of the six grantees encouraged participants to consider careers as peer recovery specialists and supported training or paid work experience to assist with certification. Grantees also supported training for incumbent workers to build workforce capacity to serve people with opioid use disorder and worked with employers to promote recovery-friendly workplaces.
- **Partnerships with the behavioral health system were reported as critical for grant implementation.** Since the inception of the NHE demonstration grants, DOL has recognized the importance of partnerships between the workforce and behavioral health systems. Many of the relationships were new, and partners struggled at times to define the purpose of the partnerships. In some cases, behavioral health partners were viewed as sources for mutual referrals or "hosts" for workforce staff. In other cases, partners collaborated to co-create new programs such as a specialized work readiness training for individuals in recovery. We did not observe service models where workforce development and behavioral health staff coordinated to provide integrated employment and treatment services.
- **Aligning the expectations of workforce development and behavioral health partners was challenging due to differences in culture and operations.** In particular, the systems had different conceptions of "work readiness." Behavioral health partners expected that anyone who wanted to work would be eligible for AJC services, but AJCs turned down some potential clients with opioid use disorder whom they deemed not ready to take advantage of their services.
- **Flexible grant eligibility requirements allowed states to take different approaches to participant recruitment, and the approaches were associated with differences in participant characteristics.** Four grantees relied heavily on recruiting participants through behavioral health partner organizations and on-site outreach at treatment facilities and recovery organizations; the other two grantees primarily screened people already seeking AJC services. States with a targeted approach to participant recruitment enrolled more participants with barriers to employment, including prior justice involvement, being homeless at enrollment, having a disability, and not being employed at the time of program entry.
- **Frontline staff and administrators identified the need for intensive case management.** People in recovery recruited through partnerships with behavioral health providers had complex needs and required more support than clients typically served at AJCs. Even when grantees adjusted staffing models to provide more intensive case management, the approaches were still significantly "lighter touch" than evidence-based approaches to supported employment such as individual placement and support (Elkin and Freedman 2020).

- **Efforts to train AJC staff on how to interact with people in recovery appear potentially promising.** Two of the grantees offered training for AJC staff on topics such as substance use disorders, what it means to be in recovery, and how to interact with people with opioid use disorder in a sensitive manner (such as by using person-first language) to help break down stigma around working with people in recovery and improve the experience of people in recovery who seek services at AJCs. Having trainers with lived experience seemed particularly impactful to interview respondents.
- **Grantees reported substantial labor market demand and participants interested in peer recovery occupations, but labor market information about these careers is relatively limited.** The Bureau of Labor Statistics does not track peer recovery specialists as a distinct occupation. To better understand the potential earnings of people entering these positions, more labor market information is needed, along with information on possible career paths and opportunities for advancement. Although peer specialists may eventually pursue other credentials, such as becoming licensed alcohol and drug counselors, those roles differ in that they do not involve sharing one's own lived experience. Some in the peer specialist field have expressed concerns that the "professionalization" of peer support could jeopardize workers' ability to speak to their own lived experience, thereby diluting the unique value of support provided by peers (Chapman et al. 2018; Blash et al. 2015).
- **The workforce system may be able to support a community's recovery infrastructure by helping employers provide recovery-friendly workplaces**. Providing technical assistance to employers through incumbent worker training, recovery-friendly workplace initiatives, and learning communities such as Project ECHO can magnify the workforce system's impact on the outcomes of individuals in recovery.

The NHE demonstration grantees piloted a number of innovative approaches for the workforce systems to help address the effects of the opioid crisis through supporting the employment of people with opioid use disorder, improving the ability of workers in health care and other sectors to respond to the crisis, and helping employers to support employees in recovery. This was a pioneering demonstration that provided states with flexibility to build new partnerships and pursue strategies that responded to local needs. The evaluation highlights potential strategies that state and local workforce areas may want to consider as components of targeted efforts to serve individuals in recovery, as well as broader efforts to ensure that the workforce system and labor market are welcoming to all.

Overall, research on employment and training services and opioid use disorder is still in its infancy. As states and communities across the country pilot new service models and partnerships, there is a critical opportunity to build knowledge about what works and for whom. Research will be needed on not only the implementation of the interventions, but also on how these interventions affect individuals' employment and earnings over time. Building evidence about the effectiveness of the different approaches may also require exploring creative adaptations to funding, structure, and performance measurement so that the workforce system will be better able to help the affected population. Finally, testing models, such as individual placement and support, which have shown to be effective with other subgroups is another avenue for research on how best to serve individuals with substance use disorder and to help them succeed in the labor market.

References

Blash, Lisel, Krista Chan, and Susan Chapman. "The Peer Provider Workforce in Behavioral Health: A Landscape Analysis." UCSF Health Workforce Research Center on Long-Term Care, November 9, 2015. Available at https://healthworkforce.ucsf.edu/sites/healthworkforce.ucsf.edu/files/Report-Peer_Provider_Workforce_in_Behavioral_Health-A_Landscape_Analysis.pdf. Accessed August 16, 2021.

Brandeis Opioid Resource Connector. "New Hampshire's Recovery Friendly Workplace." Available at https://opioid-resource-connector.org/index.php/program-model/new-hampshires-recovery-friendly-workplace. 2020. Accessed July 20, 2021.

CDC. "Overdose Deaths Accelerating During COVID-19." December 2020. Available at https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html. Accessed May 19, 2021.

Center for Substance Abuse Treatment. "Integrating Substance Abuse Treatment and Vocational Services." Treatment Improvement Protocol (TIP) Series, No. 38. HHS Publication No. (SMA) 12-4216. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2000.

Centers for Disease Control and Prevention (CDC). March 2021. Available at https://www.cdc.gov/drugoverdose/deaths/index.html. Accessed May 19, 2021.

Centers for Medicare & Medicaid Services (CMS). *CMS State Medicaid Directors Letter: Using Peer Support Services Under Medicaid.* Baltimore, MD: HHS. 2007. Available at https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd081507a.pdf. Accessed July 12, 2021.

Chapman, Susan A., Lisel K. Blash, Kimberly Mayer, and Joanne Spetz. "Emerging Roles for Peer Providers in Mental Health and Substance use Disorders." *American Journal of Preventive Medicine,* vol. 54, no. 6, 2018, pp. S267–S274.

Chen, Allen. "Peer support specialist." *Career Outlook,* U.S. Bur f Labor Statistics, October 2017. Available at https://www.bls.gov/careeroutlook/2017/youre-a-what/peer-support-specialist.htm?view_full. Accessed July 12, 2021.

Council of Economic Advisers. "The Underestimated Cost of the Opioid Crisis." Washington, DC: White House, Council of Economic Advisers, November 2017.

D'Amico, Ronald, Kate Dunham, Verenice Chavoya-Perez, Deborah Kogan, Melissa Mack, Marian Negoita, Anne Paprocki, Sheena McConnell, and Linda Rosenberg. "Providing Public Workforce Services to Job Seekers: Implementation Findings on the WIA Adult and Dislocated Worker Programs." Report prepared for the U.S. Department of Labor. Washington, DC: Mathematica Policy Research, 2015. Available at https://wdr.doleta.gov/research/FullText_Documents/ETAOP-2016-03-Evaluation-Implementation-Report-%28accessible%20pdf%29.pdf. Accessed November 25, 2019.

DeFulio, Anthony, Jeffrey J. Everly, Jeannie-Marie S. Leoutsakos, Annie Umbricht, Michael Fingerhood, George E. Bigelow, and Kenneth Silverman. "Employment-Based Reinforcement of Adherence to an FDA Approved Extended Release Formulation of Naltrexone in Opioid-Dependent Adults: A Randomized Controlled Trial." *Drug and Alcohol Dependence,* vol. 120, no. 1-3, 2012, pp. 48–54.

Dunham, Kate, Anne Paprocki, Caitlin Grey, Samina Sattar, and Grace Roemer. "Change and Continuity in the Adult and Dislocated Worker Programs under WIOA." Princeton, NJ: Mathematica, November 2020.

Elkin, Sam, and Lily Freedman. Individual Placement and Support: Background and Directions for Future Research. OPRE Report 2020-139. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, December 2020.

Evans, Elizabeth, Yih-Ing Hser, and David Huang. "Employment Services Utilization and Outcomes Among Substance Abusing Offenders Participating in California's Proposition 36 Drug Treatment Initiative." *Journal of Behavioral Health Services & Research*, vol. 37, no. 4, 2010, pp. 461–476.

Everly, Jeffrey J., Anthony DeFulio, Mikhail N. Koffarnus, Jeannie-Marie S. Leoutsakos, Wendy D. Donlin, Will M. Aklin, Annie Umbricht, Michael Fingerhood, George E. Bigelow, and Kenneth Silverman. "Employment-Based Reinforcement of Adherence to Depot Naltrexone in Unemployed Opioid-Dependent Adults: A Randomized Controlled Trial." *Addiction,* vol. 106, no. 7, 2011, pp. 1309–1318.

Gagne, Cheryl A., Wanda L. Finch, Keris J. Myrick, and Livia M. Davis. "Peer Workers in the Behavioral and Integrated Health Workforce: Opportunities and Future Directions." *American Journal of Preventive Medicine,* vol. 54, no. 6, 2018, pp. S258–S266.

Health Resources and Services Administration/National Center for Health Workforce Analysis; Substance Abuse and Mental Health Services Administration/Office of Policy, Planning, and Innovation. "National Projections of Supply and Demand for Behavioral Health Practitioners: 2017-2030." Rockville, MD: National Center for Health Workforce Analysis, 2020.

Holcomb, Pamela, Linda Rosenberg, Elizabeth Brown, Brittney English, Kate Dunham, and Hannah Betesh. "An Institutional Analysis of American Job Centers: Study Highlights." Report prepared for the U.S. Department of Labor. Washington, DC: Mathematica Policy Research, April 2018. Available at https://www.dol.gov/sites/dolgov/files/OASP/legacy/files/StudyHighlights-AJCs.pdf. Accessed November 25, 2019.

Johansen, Karl J. "Comparing the Use of Peer Workers in Different Countries." *Scientific Annals of the Alexandru Ioan Cuza University, Iaşi. Sociology & Social Work,* vol. 10, no. 1, 2017, pp. 44–56.

Krueger, Alan B. "Where Have All the Workers Gone? An Inquiry into the Decline of the U.S. Labor Force Participation Rate." *Brookings Papers on Economic Activity,* vol. 2017, no. 2, 2017, pp. 1–87.

Merrick, Elizabeth L., Sharon Reif, Deirdre Hiatt, Dominic Hodgkin, Constance M. Horgan, and Grant Ritter. "Substance Abuse Treatment Client Experience in an Employed Population: Results of a Client Survey." *Substance Abuse Treatment, Prevention, and Policy,* vol. 7, 2012. doi:10.1186/1747-597X-7-4.

National Academies of Sciences, Engineering, and Medicine. "Medications for Opioid Use Disorder Save Lives." Washington, DC: The National Academies Press, 2019. https://doi.org/10.17226/25310.

National Safety Council. "Poll: 75% of Employers Say Their Workplace Impacted by Opioid Use." 2019. Available at https://www.nsc.org/in-the-newsroom/poll-75-of-employers-say-their-workplace-impacted-by-opioid-use. Accessed May 1, 2019.

"NH Governor's Recovery Friendly Workplace Initiative." 2020. Available at https://www.recoveryfriendlyworkplace.com/sites/default/files/2020-07/RFW%201-Pager.pdf. Accessed July 20, 2021.

Petry, Nancy M., Leonardo F. Andrade, Carla J. Rash, and Martin G. Cherniack. "Engaging in Job-Related Activities Is Associated with Reductions in Employment Problems and Improvements in Quality of Life in Substance Abusing Patients." *Psychology of Addictive Behaviors: Journal of the Society of Psychologists in Addictive Behaviors,* vol. 28, no. 1, 2014, pp. 268–275.

Reif, Sharon, Lisa Braude, D. Russell Lyman, Richard H. Dougherty, Allen S. Daniels, Sushmita Shoma Ghose, Onaje Salim, and Miriam E. Delphin-Rittmon. "Peer Recovery Support for People with Substance Use Disorders: Assessing the Evidence." *Psychiatric Services*, vol. 65, no. 7, July 2014, pp. 853–861.

Rowe, Gretchen, Jillian Berk, and Jessica Ziegler. "Evaluation of Waivers Granted Under WIA: Findings from Interviews with 20 States." Submitted to the U.S. Department of Labor, Employment and Training Administration. Washington, DC: Mathematica Policy Research, April 2012. Available at https://mathematica.org/publications/evaluation-of-waivers-granted-under-wia-findings-from-interviews-with-20-states.

Sherba, R. T., Kathryn A. Coxe, Beth E. Gersper, and Jessica V. Linley. "Employment Services and Substance Abuse Treatment." *Journal of Substance Abuse Treatment,* vol. 87, 2018, pp. 70–78.

Sinakhone, Joyce K., Bronwyn A. Hunter, and Leonard A. Jason. "Good Job, Bad Job: The Employment Experiences of Women in Recovery from Substance Abuse." *Work,* vol. 57, no. 2, 2017, pp. 289–295.

Substance Abuse and Mental Health Services Administration (SAMHSA). "Bringing Recovery Supports to Scale: Peers." 2021. Available at https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers. Accessed August 3, 2021.

Substance Abuse and Mental Health Services Administration (SAMHSA). "What Are Peer Recovery Support Services?" HHS Publication No. (SMA) 09-4454. Rockville, MD: SAMHSA Center for Substance Abuse Treatment, 2009. Available at https://store.samhsa.gov/product/What-Are-Peer-Recovery-Support-Services-/SMA09-4454. Accessed July 12, 2021.

Vine, Michaela, Colleen Staatz, Crystal Blyler, and Jillian Berk. "The Role of the Public Workforce System and Employers in Addressing the Opioid Crisis: A Review of the Literature." Cambridge, MA: Mathematica Policy Research, December 2019.

Wagner, Karla D., L. James Bovet, Bruce Haynes, Alfred Joshua, and Peter J. Davidson. "Training Law Enforcement to Respond to Opioid Overdose with Naloxone: Impact on Knowledge, Attitudes, and Interactions with Community Members." *Drug and Alcohol Dependence,* vol. 165, 2016, pp. 22–28.

U.S. Department of Labor. "National Health Emergency Demonstration Grants to Address the Opioid Crisis." Training and Employment Guidance Letter, No. 12-17, March 2018. Available at https://wdr.doleta.gov/directives/attach/TEGL/TEGL_12-17_Acc.pdf. Accessed June 15, 2021.

This page has been left blank for double-sided copying.

Appendix A.
Grantee Profiles

This page has been left blank for double-sided copying.

Grantee profile: Alaska

Grantee name: Alaska Department of Labor and Workforce Development

Grant amount: $1,263,194

Grant structure

The NHE demonstration grant was administered through the state of Alaska, which runs the state's American Job Centers (AJCs). The state awarded subgrants to employers for incumbent worker training and to four subgrantees: (1) the Regional Alcohol and Drug Abuse Counselor Training Program (RADACT), which provided training for Chemical Dependency Counselors; (2) the Department of Vocational Rehabilitation and the Southeast Regional Resource Center (SERRC), Alaska's Educational Resource Center, which implemented transition camps for youth; (3) the Alaska State Hospital and Nursing Association, which trained emergency department workers; and (4), the Addictions Academy, which provided first responder addiction education to first responder organizations across the state.

Major grant strategies

1. **Providing services to grant-eligible individuals through AJCs.** These services were similar to those that Alaska was already offering through its AJCs, and included career and training opportunities, including apprenticeships with small health care employers. The state added a question to the intake form to determine eligibility for this grant for training or support service funding. All of the 14 AJCs across the state could utilize grant funding.
2. **Training law enforcement and other community stakeholders** (small to medium-size businesses with 50 or fewer employees) on helping someone at risk or impacted by opioid use disorder. This training was offered to two police departments (Kodiak and Nome) and to others in the community, usually in the behavioral health or other medical field. Participants were allowed to choose their own training provider to provide training to their staff on identifying and assisting individuals with opioid use disorder.
3. **Training emergency room nurses and staff** on the opioid crisis and how to avoid staff burnout. The Alaska State Hospital and Nursing Home Association offered this training; more than 100 participants went through the training before it was put on hold due to COVID.
4. **Training Chemical Dependency Counselors.** In Alaska, counselors now need to have a Chemical Dependency Counselor II (CDC-II) license, which is an increased credential, to provide substance use disorder counseling. The grant funded trainings for CDC-I, CDC-II, and Counselor Technicians for program participants referred from AJCs or from employers.
5. **Providing transition career exploration camps for youth** from families affected by substance use disorders and youth with disabilities. The camps were three to five days long and were offered through a collaboration between the Department of Vocational Rehabilitation and SERRC, Southeast Alaska's Educational Resource Center. In the second year of the grant, Alaska planned more in-depth camps held on-site at employers to allow youth to explore health careers, but those were postponed due to COVID-19 restrictions.
6. **Training teachers to help identify and address potential opioid issues with students.** This was a planned activity that had little interest—first because of delays due to the COVID-19 pandemic, and then because of lack of interest from potential training participants.

7. **Training first responders and stakeholders.** Under a February 2021 grant modification, The Addictions Academy provided online interactive First Responder Addiction Education training to 20 Alaska first responder organizations. The academy allowed first responder organizations to invite other community stakeholders to increase community knowledge and insight to combat the opioid crisis, protect first responders, and give them the understanding they need to be part of the solution.

Grantee profile: Maryland

Grantee name: Maryland Department of Labor, Licensing and Regulation

Grant amount: $1,975,085

Grant structure

Maryland used two approaches for its grant:

1. **Providing Opioid Workforce Innovation Funds (OWIF) to 15 subgrantees**, including nonprofit organizations, community health-based organizations, and local workforce development areas, to provide occupational training and placement, as well as peer recovery specialist certification, for individuals. These grants were capped at $75,000 each.
2. **Providing funding to eight Local Workforce Development Areas (LWDAs)** to provide general employment and training services, as well as peer recovery specialist certification, for individuals directly and indirectly affected by the opioid crisis.

Major grant strategies

Appendix Exhibit A.1. Opioid Workforce Innovation Funds recipients by topic area

Topic area	OWIF Recipients
General employment and training services	*Civic Works* *Concerted Care Foundation* *Jane Addams Resource* *Maryland New Directions* *Susquehanna Workforce Network* *The National Center on Institutions and Alternatives* *Vehicles for Change*
Soft skills training and other training opportunities	*Horizon Goodwill Inc.*
Transitional jobs in hospitality industry	*The Light House*
Training for individuals leaving incarceration	*Maryland Reentry Resource Center*
Certified Peer Recovery Specialists training	*Helping Up Mission* *Westminster Rescue Mission*
Health care occupational training	*Baltimore Alliance for Careers in Healthcare*

Source: Grantee Quarterly Narrative Progress Reports and site visit interviews.

Funding for Local Workforce Development Areas (LWDAs). This strategy provided funding to eight LWDAs to train and place participants directly or indirectly affected by the opioid crisis. Grant participants received training in health care, cosmetology, construction, and hospitality, as well as Certified Peer Recovery Specialist training. Some of these LWDAs implemented innovative partnerships with behavioral health services providers; for example, Western Maryland Consortium partnered with a community college to provide training services on-site at a residential behavioral health treatment provider.

Grantee profile: New Hampshire

Grantee name: New Hampshire Department of Business and Economic Affairs, Office of Workforce Opportunity

Grant amount: $5,000,000

Grant name: New Hampshire Works for Recovery

Grant structure

New Hampshire administered its NHE demonstration grant through the New Hampshire Department of Business and Economic Affairs, Office of Workforce Opportunity. Southern New Hampshire Services (SNHS) was contracted to serve as the local program operator. SNHS is a longstanding member of the American Job Centers and is also the local operator of the state's WIOA Adult program. Services were available throughout the entire state and staff were strategically stationed in regions that had been hardest hit by the opioid crisis. SNHS issued a subgrant to the Community College System of New Hampshire, to adapt its existing work readiness training program to better serve people in recovery. SNHS also contracted with the Community Development Finance Authority (CDFA) for the development of training and marketing tools to support the State's Recovery Friendly Workplace Initiative. In the wake of the COVID-19 pandemic, SNHS subcontracted with SOS Recovery Center, to help potential grant participants obtain the documentation needed for grant eligibility and to provide tele-recovery services to participants.

Major grant strategies

1. **Providing employment and training services to individuals directly or indirectly affected by the opioid crisis**. This strategy was similar to the services that New Hampshire was already offering though the state's AJCs, with a new focus on individuals directly and indirectly affected by the opioid crisis. Through the grant, Southern New Hampshire Services developed relationships with referral partners serving individuals in recovery to refer potential participants to grant services at the AJCs. In the last year of the grant, New Hampshire expanded eligibility for these services to individuals living in zip codes that were highly affected by the opioid crisis. New Hampshire also developed a work readiness training specifically for individuals in recovery that was offered at recovery centers.
2. **Supporting individuals to become Certified Recovery Support Workers (CRSWs),** which is the name for the peer recovery specialist position in New Hampshire. Although New Hampshire was not able to pay for the training for this position using grant funds—as most organizations in New Hampshire certifying CRSWs are not WIOA-eligible training providers—the state helped participants obtain the 500 hours of field experience they needed for certification by developing on-the-job training placements for CRSWs with employers. The grant also paid certification exam fees for participants.
3. **Providing training and ongoing support for employers on working with people in recovery.** New Hampshire worked in partnership with the state's Recovery Friendly Workplace initiative (which is not funded through the grant) to try to match recovery-friendly employers who had job openings with qualified job seekers. The grant also funded a small subcontract to the state's Community Development Finance Authority to develop technical assistance and training materials for recovery-friendly workplaces.

Grantee profile: Pennsylvania

Grantee name: Pennsylvania Department of Labor and Industry (L&I)

Grant amount: $4,997,287

Grant structure

Pennsylvania's grant included four subgrantees, all of which were Workforce Development Boards. The grant also included one statewide strategy (Project ECHO for employers). These were the four subgrantees:

- Central Pennsylvania Workforce Development Corporation
- Philadelphia Works, Inc. [37]
- Southwest Corner Workforce Development Board
- Westmoreland-Fayette Workforce Investment Board

Major grant strategies

1. **Providing employment supports to individuals with opioid use disorder** through the PA CareerLink (AJCs). Each Workforce Development Board used different strategies to recruit grant participants. For example, Southwest Corner used a liaison who conducted outreach to recovery-focused organizations in the community and accompanied participants to the AJC, and Philadelphia Works contracted with a subgrantee, JEVS Human Services, which placed employment services staff at an outpatient opioid treatment facility.
2. **Training Certified Recovery Specialists (CRS),** which is the name for the peer recovery position in Pennsylvania. The subgrantees recruited participants interested in entering the position and offered training through training partners. In Philadelphia, the subrecipient District 1199c Training Fund also offered training for supervisors of CRS.
3. **Professional development training for the health care workforce and human service organizations.** Philadelphia and Central Pennsylvania trained emergency department workers on how to best serve individuals with opioid use disorder. Another subrecipient in Philadelphia trained human service professionals through a professional development training called Opioid Crisis Training. Southwest Corner and Westmoreland also trained ambulance services and EMT providers.
4. **Engaging employers to support employees in recovery.** At the state level, Pennsylvania reached employers via Project ECHO: Supporting Employers, Supporting Employees in Recovery, a virtual 10-session series designed to provide employers with the knowledge, resources, and best practices to support employees in recovery.

[37] Philadelphia works had three subrecipients: (1) JEVS Human Services, which provided employment services to individuals with opioid use disorder; (2) Jefferson University Hospital, which provided training on the opioid crisis to emergency department workers; and (3) District 1199c Training Fund, which trained individuals to become Certified Recovery Specialists (CRS) and CRS supervisors, and provided opioid crisis training.

Grantee profile: Rhode Island

Grantee name: Rhode Island Department of Labor and Training

Grant amount: $3,894,875

Grant name: Recovery Through Opportunity

Grant structure

Rhode Island's grant operated statewide and was administered through the Department of Labor and Training, which runs the state's American Job Centers (AJCs) and operates sector-specific partnerships with employers called Real Jobs partnerships. Subgrantees included the following:

- Building Futures/Apprenticeship RI[38]
- PVD HealthWorks
- Healthy Jobs RI/RI College
- Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
- Rhode Island Department of Health
- Workforce Solutions of Providence/Cranston
- Workforce Solutions of Greater Rhode Island
- Skills for Rhode Island's Future

Major grant strategies

1. **Connecting job seekers at AJCs from communities highly affected by the opioid crisis with career training/placement and supportive services.** The grant funded employment and training services for individuals seeking AJC services who live in zip codes that are highly affected by the opioid crisis. These individuals would not necessarily know these services were funded by the NHE demonstration grant. The grant also hired an employee to conduct outreach to recovery houses and other recovery community organizations to recruit participants and refer them to services at AJCs.
2. **Providing career/training and addiction education for the construction workforce (entrants and incumbent workers) and other affected sectors.** Building Futures, a subgrantee, provided career/training services through its existing construction sector pre-apprenticeship program. In addition to funding these employment and training services, it used grant funding to develop an opioid education curriculum that was piloted during the construction pre-apprenticeship training program. Building Futures then worked with construction sector unions and other employers to implement the curriculum for incumbent workers.
3. **Providing training and apprenticeships for peer recovery specialists and community health workers.** A subgrantee, Healthy Jobs RI, used grant funding to train community health workers (CHWs), and it looked at the overlap between peer recovery specialists (PRS) and CHWs and developed a curriculum to cross-train individuals in these professions. It also developed specialty tracks for CHWs on chronic pain self-management and geriatric issues. Another subgrantee, Apprenticeship RI (which is housed at Building Futures), worked with two subrecipients to create

[38] Has two subrecipients, Parent Support Network and Parent Information Network.

CHW and dual CHW-PRS registered apprenticeships. The state also trained PRS on medication-assisted treatment for opioid use disorder.

4. **Training AJC and community-based organization (CBO) staff to identify and better serve people with opioid use disorder.** The state contracted with PVD Works and Healthy Jobs RI to develop a curriculum for staff at AJCs and CBOs providing employment services to train them to better serve people with opioid use disorder. These trainings were offered to up to seven sessions of up to 20 people each starting in January 2021.
5. **Engaging employers to create recovery-friendly workplaces.** The state used grant funding to start a statewide Recovery Friendly Workplace initiative, which is now housed at Rhode Island College. This is modeled after New Hampshire's Recovery Friendly Workplace initiative and was developed in partnership with the state's overdose prevention task force.

Grantee profile: Washington

Grantee name: Washington State Employment Security Department

Grant amount: $4,892,659

Washington's grant focused on two local workforce development councils: Snohomish and Pacific Mountain. These subgrantees designed their programs separately and implemented distinct strategies.

Grant structure

Major grant strategies

Snohomish strategies included the following:

1. **Co-locating workforce services** at a "one-stop shop" (called the Carnegie Resource Center), which offered many other resources including diversion and behavioral health services. By utilizing a co-location strategy, Snohomish was able to recruit participants where they were already receiving behavioral health services.
2. **Developing transitional jobs for people with opioid use disorder.** Snohomish used the grant to implement transitional jobs, or subsidized work experience, for the first time. This strategy was focused on individuals with opioid use disorder who were new entrants in the workforce, who were primarily placed with community-based organization (CBO) employers. Participants were placed in transitional jobs for 300 hours and earned similar wages to those hired permanently.
3. **Using employment navigators, hired through CBOs,** to facilitate employment-related services and support services. These navigators reached additional communities, such as immigrants and refugees, and leveraged their own organization's resources to help their participants. The employment navigators worked out of the Carnegie Resource Center and other community sites.

Pacific Mountain strategies included the following:

1. **Providing employment services through contracted direct service providers.** These staff offered career guidance, job readiness assessments, job placement support, work experience, and job shadowing or internships.
2. **Training Certified Peer Counselors**. Pac Mountain worked with a training provider partner to offer Certified Peer Counselor trainings. Pac Mountain enrolled each training participant in employment services and in an internship program after the training.
3. **Offering reentry workshops and work readiness services** for justice-involved individuals. This was an expansion on work Pac Mountain had already been running with a local jail as part of its chemical dependency program.
4. **Expanding the Washington Recovery Helpline,** a hotline for recovery services, to the Pac Mountain region.
5. **Offering a construction pre-apprenticeship program** through a training partner in the area called ANEW. This program focused on participants who were female or people of color.

Appendix B.
Supplemental Workforce Integrated Performance System (WIPS) Tables

This page has been left blank for double-sided copying.

Appendix Exhibit B.1. Participant enrollment, by NHE demonstration grantee and program-year quarter

	All	AK	MD	NH	PA	RI	WA
Program-year quarter of enrollment							
Before PY2018Q1	22	14	1	0	1	1	5
PY2018Q1	10	5	0	0	2	1	2
PY2018Q2	30	7	4	7	6	0	6
PY2018Q3	155	13	12	28	53	15	34
PY2018Q4	371	12	67	54	46	40	152
PY2019Q1	450	38	58	37	66	75	176
PY2019Q2	697	30	41	43	87	361	135
PY2019Q3	697	55	75	37	46	378	106
PY2019Q4	344	25	7	8	11	287	6
PY2020Q1	121	22	n.a.	20	28	26	25
PY2020Q2	88	8	n.a.	24	20	11	25
PY2020Q3	0	0	n.a.	0	0	0	0
Total	2,985	229	265	258	366	1,195	672

Source: WIPS data through March 31, 2021.

Notes: Sample is 2,985 participants enrolled by the NHE demonstration grantees by March 31, 2021. Maryland's grant ended at the end of PY2019.

AK = Alaska; MD = Maryland; NH = New Hampshire; PA = Pennsylvania; PY = Program Year; Q = Quarter; RI = Rhode Island; WA = Washington; n.a. = not applicable.

Appendix Exhibit B.2. Participant characteristics, by NHE demonstration grantee

	All	AK	MD	NH	PA	RI	WA
Age (years)							
18-24	14.3%	25.8%	14.7%	5.0%	6.6%	17.1%	13.2%
25-34	31.1%	34.5%	28.7%	29.1%	34.2%	33.8%	25.0%
35-44	24.1%	25.3%	24.2%	24.8%	28.1%	20.4%	27.5%
45-54	18.5%	11.4%	16.2%	24.0%	22.1%	17.9%	18.9%
55 or older	11.3%	3.1%	16.2%	17.1%	9.0%	10.8%	12.2%
Sex							
Female	52.8%	57.6%	46.8%	58.9%	57.9%	57.1%	40.8%
Male	45.8%	42.4%	52.5%	40.7%	42.1%	42.3%	54.3%
Did not self-identify	1.4%	0.0%	0.8%	0.4%	0.0%	0.6%	4.9%
Race and ethnicity							
Hispanic	9.5%	6.1%	3.0%	3.1%	3.3%	15.8%	7.7%
White, non-Hispanic	57.2%	55.9%	43.0%	82.6%	73.8%	45.4%	65.3%
Black, non-Hispanic	11.0%	4.8%	38.9%	5.0%	17.2%	8.0%	6.1%
Asian, non-Hispanic	2.6%	7.0%	0.4%	0.4%	0.0%	2.4%	4.5%
American Indian / Alaska Native	1.5%	10.5%	0.0%	0.8%	0.5%	0.3%	1.9%
Native Hawaiian / Other Pacific Islander	0.4%	2.6%	0.0%	0.4%	0.3%	0.0%	0.6%
More than one race	3.0%	10.5%	3.4%	2.3%	1.9%	1.8%	3.4%
Did not self-identify	14.9%	2.6%	11.3%	5.4%	3.0%	26.3%	10.4%
Educational attainment							
No high school diploma or GED certificate	8.3%	2.2%	7.9%	6.6%	10.1%	3.3%	19.0%
High school diploma or GED certificate	44.3%	42.4%	61.5%	38.8%	66.4%	32.1%	49.9%
Some postsecondary education	29.9%	44.1%	21.5%	39.1%	18.6%	33.0%	25.7%
Bachelor's degree or more	17.5%	11.4%	9.1%	15.5%	4.9%	31.6%	5.4%
Reported a disability	13.4%	10.0%	27.5%	21.3%	26.5%	2.1%	18.9%
Employed at program entry	37.0%	46.7%	18.9%	15.1%	31.7%	60.8%	9.7%
Classified as low-income	71.9%	44.5%	83.4%	42.6%	82.2%	90.6%	49.3%
Veteran	3.0%	6.1%	5.3%	1.6%	4.6%	1.6%	3.3%
Ex-offender	21.3%	7.4%	49.4%	24.0%	39.6%	1.9%	40.1%
English language learner	3.4%	0.4%	0.4%	0.8%	1.1%	4.9%	5.1%
Homeless	8.5%	3.5%	20.7%	5.0%	7.1%	0.8%	21.1%

Source: WIPS data through March 31, 2021.

Notes: Sample is 2,985 participants enrolled by the NHE demonstration grantees by March 31, 2021. Maryland's grant ended at the end of PY2019.

AK = Alaska; MD = Maryland; NH = New Hampshire; PA = Pennsylvania; RI = Rhode Island; WA = Washington; n.a. = not applicable.

Appendix Exhibit B.3. Occupational training area, by NHE demonstration grantee

	All	AK	MD	NH	PA	RI	WA
Occupational training area							
Management	6.4%	0.0%	1.4%	4.4%	0.9%	9.6%	1.7%
Business and financial operations	1.1%	0.0%	2.0%	3.5%	0.5%	1.0%	1.7%
Computer and mathematical	10.6%	1.0%	2.0%	9.7%	0.5%	16.0%	0.0%
Architecture and engineering	9.5%	1.0%	1.4%	4.4%	0.0%	14.8%	0.0%
Life, physical, and social science	0.1%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%
Community and social service	15.9%	7.0%	12.9%	10.6%	56.5%	11.2%	5.1%
Educational instruction and library	0.1%	0.0%	0.7%	0.0%	0.5%	0.0%	0.0%
Arts, design, entertainment, sports, and media	2.0%	0.0%	0.0%	2.7%	0.0%	3.1%	0.0%
Health care practitioners and technical	10.4%	40.8%	4.1%	6.2%	17.6%	5.4%	1.7%
Health care support	12.7%	11.4%	8.2%	16.8%	1.4%	15.4%	10.2%
Food preparation and serving related	0.4%	0.0%	0.7%	0.9%	0.5%	0.2%	5.1%
Building and grounds cleaning and maintenance	0.4%	0.5%	0.0%	0.0%	0.5%	0.4%	1.7%
Personal care and service	0.6%	1.5%	0.7%	0.9%	0.0%	0.5%	1.7%
Sales and related	0.5%	0.0%	2.7%	1.8%	0.0%	0.1%	3.4%
Office and administrative support	4.8%	2.0%	10.9%	9.7%	2.3%	4.6%	3.4%
Construction and extraction	9.2%	7.0%	10.2%	1.8%	2.8%	11.3%	10.2%
Installation, maintenance, and repair	1.4%	6.5%	1.4%	1.8%	1.9%	0.5%	0.0%
Production	3.1%	1.0%	13.6%	3.5%	3.7%	2.2%	0.0%
Transportation and material moving	9.3%	13.4%	21.1%	19.5%	10.6%	3.4%	54.2%

Source: WIPS data through March 31, 2021.

Notes: Sample is participants enrolled by NHE demonstration grantees through March 31, 2021, who received occupational training.

AK = Alaska; MD = Maryland; NH = New Hampshire; PA = Pennsylvania; RI = Rhode Island; WA = Washington.

This page has been left blank for double-sided copying.

Appendix C.
Characteristics of Site Visit and Focus Group Respondents Among Six NHE Demonstration Grantees

This page has been left blank for double-sided copying.

We conducted virtual site visits with all six NHE demonstration grantees between November 2020 and January 2021. We interviewed respondents at both the state level (state grant directors, administrators, and state partner organizations) and the local level (subgrant directors, frontline staff, local partners, and employers). In addition, we conducted two focus groups in each state with program participants. We administered online respondent information forms to all grantee interview respondents and participant focus group members to gather information about demographic characteristics and work histories. We summarize the characteristics of interview respondents and focus group participants below.

Characteristics of interview respondents

These site visits included semistructured interviews with 108 respondents at the state and local level, including 10 state grant directors, 5 state administrators, 16 state partners, 21 local subgrant directors, 19 frontline staff, 25 local partners, and 12 employers. Eighty-seven of the interview respondents completed the online information forms.

Appendix Exhibit C.1. Interview respondents' years of experience doing the type of work on the NHE demonstration grant

Years of experience	Percentage
Less than 5 years	38%
5-10 years	32%
11-15 years	11%
16-20 years	7%
21 or more years	12%

Source: Respondent information forms administered to interview respondents.

Note: N = 73 respondents completed the question.

Appendix Exhibit C.2. Interview respondents' percentage of time spent working on NHE demonstration grant

Percentage of time	Percentage
Less than 25% time	60%
25-50% time	10%
50-75% time	7%
75-100% time	23%

Source: Respondent information forms administered to interview respondents.

Note: N = 70 respondents completed the question.

Appendix Exhibit C.3. Interview respondents' level of education

Level of education	Percentage
High school diploma or equivalent	8%
Some college	12%
Associate's degree or vocational degree	8%
Bachelor's degree	29%
Master's degree or higher	43%

Source: Respondent information forms administered to interview respondents.

Note: N = 75 respondents completed the question.

Characteristics of focus group participants

We conducted two focus groups in each state with program participants, including (1) participants directly or indirectly affected by the crisis receiving general employment and training services and (2) participants receiving training to become peer specialists or receiving training in other health care occupations to address the opioid crisis (that is, community health workers and nurses). We experienced some challenges recruiting program participants to participate in virtual focus groups. As a result, we conducted five individual interviews with program participants who were not able to participate in virtual focus groups at the scheduled times, in order to maximize the number of program participants with whom we spoke. In total, we spoke to 40 participants across focus groups and individual interviews. Twenty-four participants completed respondent information forms.

Appendix Exhibit C.4. Focus group participants' NHE demonstration grant eligibility categories

Eligibility category	Percentage
A family member of someone directly affected by the opioid crisis	50%
Currently in recovery from an opioid use disorder	46%
An addiction worker or healthcare provider receiving training to better address opioid use disorder	46%
In training to become an addiction worker or healthcare provider	25%
Other	17%

Source: Respondent information forms from 24 focus group respondents

Notes: Respondents could select more than one option. "Other" responses included in recovery from other substances and working as a service provider to people in recovery.

Appendix Exhibit C.5. How focus group participants heard about the NHE demonstration grant

How participants heard about the program	Percentage
Heard about program from family, friends, or others in community	36%
Referred by staff at an American Job Center	23%
Other	14%
Referred by treatment/recovery provider	14%
Referred by employer	9%
Referred by criminal justice system (for example, a judge, parole, or probation officer, reentry specialist)	5%

Source: Respondent information forms from 24 focus group respondents.

Notes: Respondents could only select one answer. "Other" responses included hearing about program at employment security office, from an unemployment counselor, or through a recovery coach academy.

Percentages do not sum to 100% due to rounding.

Appendix Exhibit C.6. Characteristics of focus group participants

	Percentage
Age	
Less than 25 years	9%
25-30 years	13%
31-40 years	52%
41-50 years	9%
Over 50 years	17%
Gender	
Male	25%
Female	71%
Not available	4%
Ethnicity	
Hispanic or Latino	13%
Not Hispanic or Latino	83%
Not available	4%
Race	
American Indian or Alaska Native	13%
Asian	0%
Black, African American	8%
Native Hawaiian or other Pacific Islander	4%
White	75%
Other	4%
Education	
High school diploma or equivalent	13%
Some college	35%
Associate's degree or vocational degree	30%
Bachelor's degree	13%

	Percentage
Master's degree or higher	9%
Employment status	
Currently working	65%
Not currently working	35%

Source: Respondent information forms from 24 focus group respondents.

Appendix Exhibit C.7. Types of support focus group participants have received through the NHE demonstration grant

Types of support	Percentage
Help or support training for a new career	67%
Help or support getting training to advance in their career	58%
Help or support finding a job	58%
Help or support applying for a job	42%
Help or support preparing for or attending a job interview	42%
Help or support to think about how to advance their education or career	42%
Help or support preparing a resume	29%
Help or support solving problems that arise on the job	21%
Help or support talking with employers about their need for workplace accommodations or support	17%
Other	4%

Source: Respondent information forms from 24 focus group respondents.

Notes: Respondents could select more than one option.

This page has been left blank for double-sided copying.

Mathematica Inc.

Princeton, NJ • Ann Arbor, MI • Cambridge, MA
Chicago, IL • Oakland, CA • Seattle, WA
Tucson, AZ • Woodlawn, MD • Washington, DC

EDI Global, a Mathematica Company

Bukoba, Tanzania • High Wycombe, United Kingdom

mathematica.org