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Developing a Substance Use Practice Approach for Peer Support Specialists in Early Psychosis Coordinated Specialty Care

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ABSTRACT

Introduction: Substance use is common and developmentally normative among transition-age youth and linked to poor outcomes among individuals with early psychosis. Peer Support Specialists (PSSs) are increasingly part of early psychosis Coordinated Specialty Care (CSC). CSC team substance use-specific practices are lacking despite the prevalence of CSC client substance use. This study describes the development of a substance use practice approach for CSC PSSs.

Methods: This study occurred within the 'Advancing Early Psychosis Intervention Network in Texas' (EPINET-TX), a university-affiliated Learning Health System with 15 community mental health providers and 29 CSC teams. A research team composed of a study coordinator with PSS experience, community mental health intervention researchers and a current CSC PSS leveraged EPINET-TX research findings, a literature review and expert consultation to design 'Peer Approaches to Substances for Early Psychosis Programs' (PAS-EPP). The team developed a conceptual model, practice principles and core practices and training materials.

Results: PAS-EPP has eight practice principles and four core practice domains. The PAS-EPP toolkit provides an adaptable, accessible harm reduction approach to substances for CSC PSSs intended to promote self-exploration of personal beliefs and biases, intentional sharing and team collaboration strategies and confidence building in capacity to explore and share information about substance use that is relevant to young people.

Conclusion: PAS-EPP is a promising practice approach for CSC PSSs. Future evaluation of PAS-EPP will provide insight into its feasibility and impact.

1 | Introduction

Substance use (SU) experimentation is developmentally normative during adolescence and young adulthood, the same developmental period during which approximately two-thirds of schizophrenia spectrum disorders emerge (Solmi et al. 2022).

In the United States alone, an estimated 100 000 individuals are newly diagnosed with a psychotic disorder each year (NIMH 2023). As a result, early psychosis (EP) programs routinely serve transition-age youth for whom SU is common, expected and often intertwined with developmental exploration, social connection, coping and identity formation.

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Approximately half of individuals with EP meet criteria for a co-occurring substance use disorder (Cather et al. 2018), which is more than double the rates among general population 18–25-year-olds (SAMHSA 2024). Co-occurring SU is consistently associated with worse clinical and functional outcomes, including increased symptom severity, service disengagement, psychiatric hospitalisation, justice involvement, unemployment, homelessness and poverty (Abdel-Baki et al. 2017; Colizzi et al. 2016; Fraser et al. 2023; Oluwoye et al. 2019, 2021; Ouellet-Plamondon et al. 2017; Patel et al. 2016; Schoeler et al. 2017; Weibell et al. 2017). These outcomes can undermine the core aims of EP care: early intervention, sustained engagement and recovery during a critical developmental window.

The most widely implemented U.S. EP model is Coordinated Specialty Care (CSC)—an intensive, time-limited, community—and team-based, multidisciplinary approach that integrates psychiatry, psychotherapy, supported employment/education, peer support and case management (Heinssen et al. 2014). CSC teams have several specialty staff members (including clinical and non-clinical roles) that share a caseload of young people with EP and employ shared decision making and person-centred care planning to support young person recovery and goal attainment (Heinssen et al. 2014). CSC has expanded rapidly, with approximately 360 programs currently operating nationwide (Heinssen and Azrin 2022). Despite the high prevalence of SU among individuals with EP and its well-documented negative impact on outcomes, CSC does not specialise in SU treatment. The most widely adopted CSC models (e.g., OnTrackNY; Bennett 2018) NAVIGATE (Gingerich 2020) do include SU-related practices drawing from Integrated Dual Disorders Treatment, yet these resources appear insufficient in real-world implementation. Experts note that CSC lacks an integrated, cohesive approach, shared ethos, or concrete guidance for navigating client SU beyond addressing ‘clinically relevant’ or disordered use (Bello and Dixon 2022; SAMHSA 2010). Qualitative research with staff from five U.S. CSC teams found that SU services were described as critically lacking, inconsistently applied and poorly integrated within CSC workflows (Stokes et al. 2022).

In practice, CSC licensed mental health professionals assess clinically relevant SU to determine CSC eligibility at intake and every six months (Bennett 2018; Gingerich 2020; Rosenblatt et al. 2025). Across roles (including clinical, vocational and peer support), many CSC teams screen for clinically relevant SU regularly (Bello and Dixon 2022; SAMHSA 2019). The value of a multidisciplinary team that shares a caseload is that different team members can bring information about client SU (and related struggles) to team meetings as it comes up when working with clients in real time. CSC staff (including clinical, vocational and peer roles) are trained in safety assessment and crisis protocols (Pollard and Hoge 2017). CSC team leaders are typically clinically licensed mental health professionals who support non-clinical team members navigate client substance use escalation when it occurs (Bello and Dixon 2022).

If a SU disorder is determined as the primary condition leading to psychosis, or if SU is determined clinically relevant (and disruptive to daily functioning and recovery) among CSC clients, CSC teams *refer* clients out to external specialty SU treatment (Klodnick et al. 2024). This practice gap is particularly

concerning given evidence from a systematic review indicating that reductions in SU following first-episode psychosis occur naturally for many individuals, yet are *not* observed among those receiving specialised SU treatment (Wisdom et al. 2011), suggesting that traditional SU treatment models may be ill-suited for youth with EP.

Peer Support Specialists (PSSs) are increasingly embedded within CSC teams across the United States (George et al. 2022) and represent a uniquely positioned workforce to engage young people around SU. CSC PSSs draw on their own living and lived experience with mental health challenges, recovery, treatment engagement and systems navigation to support clients’ self-defined goals (Shalaby and Agyapong 2020). PSSs adhere to national and state peer ethics codes (NAADC 2021) and most states offer training and certification pathways (SAMHSA 2023b). While CSC-specific peer values and practices are articulated in a publicly available practice manual (DuBrul et al. 2017) and emerging qualitative research (Walker et al. 2024), these resources provide limited guidance for navigating SU among young people with EP. Some—but not all—CSC PSSs personally identify as being in SU recovery and draw on those experiences in their work (Klodnick et al. 2024). Without structured, shared guidance, CSC PSSs may rely on personal belief systems or recovery paradigms that are not developmentally aligned or appropriate for all youth, leading to inconsistent practices and potential harm.

Young people with EP—and CSC staff supporting them—also need clearer, more accurate information about the complex relationships between psychosis, mental health and specific substances. Cannabis use is particularly prevalent among youth with EP (Myles et al. 2016) and is strongly associated with the onset, exacerbation and persistence of psychotic symptoms (Colizzi et al. 2016; Large et al. 2011; Myles et al. 2016). Yet both young people and mental health providers frequently misunderstand or minimise the risks associated with cannabis use in EP (Carley 2024; Sehularo et al. 2012; Weiss et al. 2024), limiting opportunities for meaningful, preventive dialogue.

Harm reduction-oriented approaches may be especially well-suited for addressing SU within EP care. Harm reduction emphasises nonjudgement, autonomy and pragmatic strategies to minimise health, social and legal harms associated with SU (SAMHSA 2023a). For adolescents and young adults, harm reduction approaches have demonstrated promise (Stockings et al. 2016), as have similar approaches among adults with serious mental health conditions (Robinson et al. 2022). In contrast, abstinence-only approaches may inadvertently increase stigma, fear and disengagement, impede autonomy and suppress open exploration of thoughts, feelings and curiosities—without equipping young people with realistic tools to reduce risk (Hanken 2022; Kimmel et al. 2021).

Effectively engaging young people with EP around SU requires a harm reduction framework grounded in nonjudgement, open-mindedness and knowledge of multiple strategies for reducing risk. However, much of the SU training currently accessible to PSSs through state certification and counsellor credentialing programs remains abstinence-based and insufficiently tailored to youth and young adults (du Plessis et al. 2020). PSSs must

be supported to apply the core peer principle of ‘meeting people where they are’ in the context of SU—prioritising safety and risk mitigation without coercing change. Because mutual sharing and perspective-taking are defining features of peer support, clear guidance is needed to help PSSs navigate SU conversations ethically, effectively and developmentally. This includes structured opportunities to examine implicit and explicit biases related to substance use, recovery and abstinence, which may otherwise constrain the ability to provide nonjudgemental, youth-centred support.

1.1 | CSC PSS SU Practice Development

Together, this evidence highlights a critical and persistent gap in EP care: CSC programs serve a population at exceptionally high risk for SU-related harm yet lack a substance use-specific, developmentally informed, harm reduction-oriented practice that is fully integrated into team-based care. This study uses evidence-based practice development strategies, including coproduction and consultation (O’Cathain et al. 2019), to design a clearly defined CSC PSS SU practice approach for a future multi-site randomised control trial within the EPINET-TX Learning Health System. For feasibility and credibility, the approach had to be strongly aligned with Peer Support philosophy and values. Peer Support operates through a ‘doing with’ approach, emphasising shared lived experience, mutuality and horizontal relationships to foster hope and recovery (Davidson et al. 2012; Mead 2005; SAMHSA 2026). Conversely, clinical interventions are often characterised as ‘doing to’ (or for) the service user, focusing on hierarchical, expert-driven care, diagnosis and symptom reduction (Bordin 1979; Davidson et al. 2007). This study describes the development and core components of a structured PSS practice approach to CSC client substance use.

2 | Methods

2.1 | Study Site

This study was conducted within the ‘Advancing Early Psychosis Intervention Network in Texas’ (EPINET-TX). EPINET-TX is facilitated by UT-Austin researchers and includes 15 public mental health providers with 29 CSC teams. Texas CSC eligibility includes individuals aged 15–30 diagnosed with a psychosis disorder (i.e., schizophrenia, affective psychosis) within the last two years. Each agency serves between 25–90 individuals at a time, depending on the number of teams operating. Most use the OnTrackNY Model (see Cohen et al. 2023) and include a Team Lead, Supported Employment/Supported Education Specialist, Skills Trainer/Case Manager, Peer Support Specialist, Family Partner and Psychiatrist or other prescriber.

2.2 | Research Team

A former young adult PSS with lived experience navigating mental health and SU treatment during their adolescence and young adulthood led practice approach development and served as the

Study Coordinator. The Study Coordinator also had training and experience in intervention development, technical writing and PSS training. A licensed counsellor with experience supervising young people with lived/living experience in research supervised the Study Coordinator and was part of the development team. The development team also included a CSC PSS lived experience consultant (recruited from the EPINET-TX Learning Health System network) and three PhD-level university-affiliated researchers. One researcher had experience as a CSC clinician and as the EPINET-TX Participatory Action Research workgroup facilitator; another had experience in intervention design, manualising and evaluation and the third had multi-site community mental health service demonstration and research experience.

2.2.1 | Practice Approach Development Process

See Figure 1 for the development process. First, the Study PI hosted a kickoff meeting to build working alliances between team members, review project goals, activities, responsibilities and timelines and develop a shared workplan.

Second, the development team reviewed and discussed existing evidence and practice models in adolescent and young adult substance use (e.g., motivational interviewing, family therapy and CBT for youth substance use disorders) (Rockhill et al. 2025; Steele et al. 2020), co-occurring dual disorders (e.g., integrated treatment models for concurrent substance use and mental health conditions) (Chetty et al. 2023; SAMHSA 2024), substance use recovery (e.g., recovery-oriented frameworks and long-term support strategies) (Eddie et al. 2025; SAMHSA 2017) and peer support (e.g., peer recovery support services shown to improve engagement and outcomes) (Finisse 2026; Scannell 2021) and CSC for example, (Bello and Dixon 2022). It was determined that a fact sheet be included on cannabis, due to its prevalence of use among CSC participants, connection with psychosis and increasing legal-ity and availability in the US.

The team also discussed recent EPINET-TX qualitative research illuminating CSC participant ($n=18$) SU perspectives, motivations and deterrents (Myers et al. 2024) and CSC PSSs ($n=20$) experience with and perspectives on navigating young person SU (Klodnick et al. 2024). CSC clients desired practical substance use information, opportunities to explore their substance use ambivalence, positive peer communities to support healthy choices and strategies for addressing psychological and physical pain that did not include substance use (Myers et al. 2024). These findings strongly align with *Recovery Capital* (Lin 2002), a theory of change related to SU in adolescents that posits how positive peer relationships, connection to groups aligned with one’s identity and community participation foster SU recovery.

CSC PSSs (and CSC team members) have a variety of lived experiences and perspectives related to SU, including some deeply embracing 12 Step Program philosophies which prioritise abstinence over harm reduction (Klodnick et al. 2024). Further, some PSSs had a desire to share negative life experiences related to their own SU to inform (and warn and

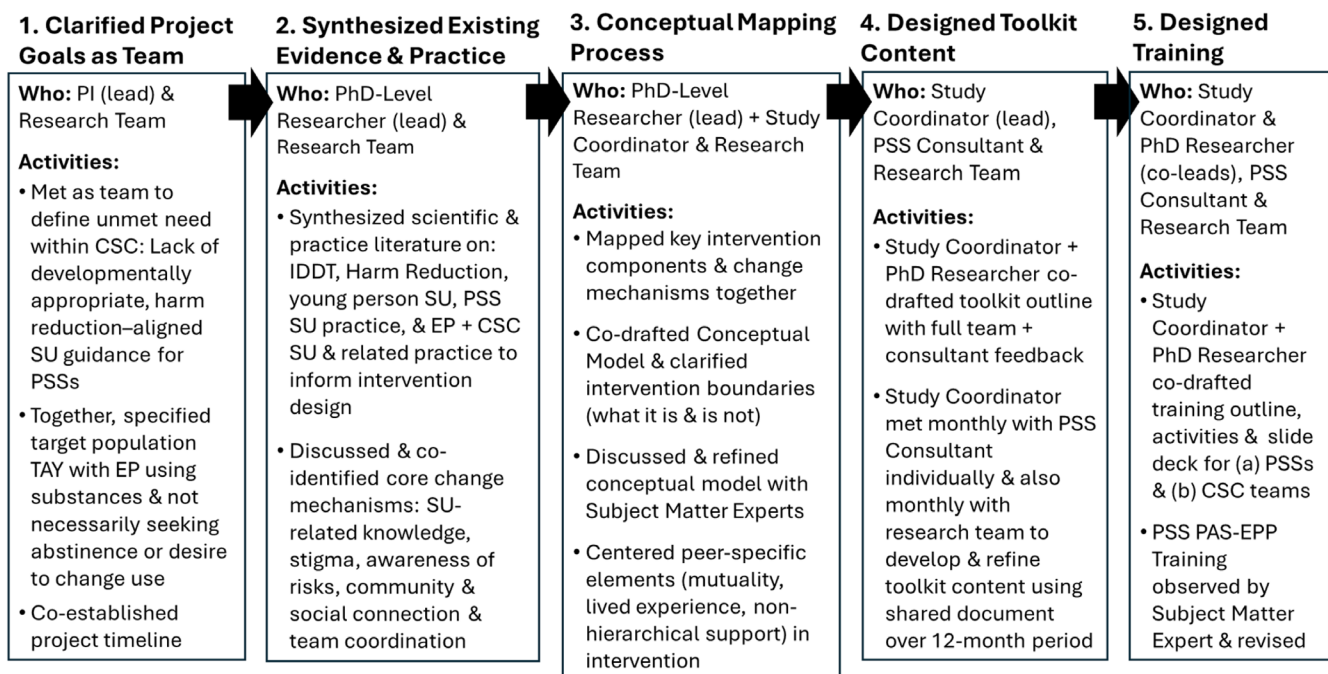


FIGURE 1 | Practice approach development process.

protect) CSC clients about the negative consequences of SU use—while others focused on being nonjudgemental and exploring SU before offering education or suggesting a behaviour change (Klodnick et al. 2024). To build an effective PSS-delivered SU practice approach, it had to include personal exploration of beliefs about and experiences with different types of substances (and treatment programs if relevant), how to share information about substances effectively and how to explore SU with clients in an authentic, nonjudgemental and morally neutral way.

Through conceptual mapping process meetings that the Study Coordinator and a researcher co-led, the team built a conceptual model, identified key practice principles and organised content into a manual. The conceptual model and toolkit sections were shared with SU and Peer Support experts who made suggestions for improving language, content and practices. After building the toolkit, the study coordinator and a PhD-level researcher co-developed training outlines for CSC teams and PSSs to support implementation of the practice approach.

3 | Results

The practice approach was named *Peer Approaches to Substances for Early Psychosis Programs (PAS-EPP)* to align with PSS practice principles. The PAS-EPP approach is intended for use with all EP clients—not only those with an identified SU disorder. The PAS-EPP harm reduction approach is intended to help young people explore curiosity about substances and reduce risk of problematic SU. PAS-EPP is a philosophy and set of practices to approach young person SU from a peer/lived experience perspective. There is no ‘one size fits all’ CSC PSS approach to SU. PSS perspectives and experiences are as unique as each young person. Instead of designing a time-limited structured intervention, the team created principles and practices for application

depending on circumstances (e.g., the extent to which a young person understands their SU as problematic or is motivated to change SU). SU approaches should adapt based on PSS-client relationships and client needs, circumstances and experiences. Increasing personal awareness, education and resources around substances is crucial to evolving PSS approaches. PAS-EPP demands a shift in personal awareness by adopting philosophical practice principles around SU as well as intentional application of a set of specific practices. PAS-EPP had eight Guiding Principles (Table 1) and four Core Practice Domains (Figure 2).

3.1 | PAS-EPP Conceptual Model

The PAS-EPP Conceptual Model (Figure 2) has four domains. Domain 1 includes practices that explore a young person's perspective, experience and beliefs around substances, validate through sharing personal experiences and connection to information for decision-making around substances. These activities help young people have greater self-awareness and information to guide their choices related to substances. Domain 2 includes activities supporting goals around SU, including exploring motivation to change, available resources, applying harm reduction and identifying personally meaningful activities. These activities will increase motivation, self-confidence and empowerment among young people to change SU behaviours. Domain 3 includes activities promoting social connections and community participation, including CSC peer support groups, SU-specific peer support and social activities. These activities will increase participation in substance-free social activities and social support. Domain 4 includes activities that PSSs do while meeting and interacting with fellow CSC teammates and includes sharing client SU information in a nonjudgemental way and advocating for nonjudgemental strategies that the CSC team can use to support client goals. These activities will improve coordinated care with clients who use substances.

TABLE 1 | PAS-EPP guiding principles.

1. Explore, Educate and Plan for SU as soon as it comes up, not waiting until SU is a problem.	The practice of ‘referring out’ to SU-specific services is common in mental healthcare, including CSC. As a result, approaching substances is often neglected until a young person has already reached the point that SU is directly impacting their life. <i>Much</i> can be done before this point. The word choice for this approach, ‘Peer Approaches to Substances’—and not <i>substance use</i>, is intentional. PAS-EPP promotes the opportunity to explore substances with young people not only when they are being used, but whenever the topic comes up. Personal biases around substances come from a combination of self, society, culture, family, systems and media. It is crucial to learn, educate and explore the potential harms that different substances may cause without perpetuating stigma. By gaining awareness of our implicit biases, we can work to become more neutral in our perspective and approach to substances and SU. ‘Moral neutrality’ simply means that PSSs seek to detach any moral judgement about SU when it comes to working with young people. An authentic peer approach is shaped by personal experiences—and it’s important to note that having a morally neutral perspective does not negate any experiences of harm caused by substance use. PSSs explore all aspects of SU with young people, including the advantages and what they like about using, in addition to how, what, when and where they are using to potentially employ strategies to reduce harm. PSSs do not need to have the answers and should not give advice or immediately educate on SU-related risks. Instead, PSSs can ask exploratory questions to more deeply understand a young person’s experiences and perspectives together.
2. Increase Self-Awareness to adopt Moral Neutrality for exploring SU in nonjudgemental way.	Young people have the ultimate choice to ‘work on’ their SU and PSSs must stay curious, honest and nonjudgemental to gain insight into all potential aspects of SU with CSC clients. When seeking to relate to a young person’s experiences, PSSs should not warn about any assumed negative outcomes of decisions or behaviours of SU. Sharing from fear or personal experience that does not match a young person’s tone, energy, situation or circumstances can fracture trust within the young person-PSS relationship. Learning how to intentionally and effectively share from lived experience is a skill that can provide validation and increase trust within the peer relationship.
3. Explore ‘Why’ first. Make no assumptions about young people’s SU or related perspectives.	Sharing about SU can feel particularly challenging or may exceed personal boundaries. PSS lived and living experiences are a point of connection and knowledge when it comes to supporting CSC clients. At the same time, personal PSS experiences may not resonate with all CSC clients. PSS do not have to hide these experiences but must consider how the impact and purpose of our sharing may differ for each individual person or moment.
4. Resist the urge to change or warn.	To collaborate with teams effectively, PSSs seek to gain understanding of their colleagues’ individual approaches and biases towards SU within their work. It is the entire CSC team’s responsibility to share what team members know with young people, families and community members about how substances can impact mental health and physical wellness. PSSs feel equipped to share resources and information about SU and harm reduction with their team.
5. Relate and validate through intentional and purposeful sharing and education.	
6. Partner with team members to understand client SU and support client SU goals.	

(Continues)

TABLE 1 | (Continued)

7. Apply a harm reduction approach by developing SU safety strategies with young people.	PSSs can partner with young people to develop SU harm reduction strategies to increase personal safety. Strategies include sharing information and resources, including overdose prevention and safer use strategies, as well as exploring who, what, where, when and why someone or something may be detrimental to a young person's sense of safety or wellbeing. PSSs collaborate with young people to identify feasible strategies to reduce risk and harm or co-create plans to change or manage their use and/or impact of SU.
8. Explore and build community.	SU commonly takes place in social settings, including important events with family and friends. To best support young people, it is critical to address personal, social, cultural and community-related factors. We have many different types of connections and each can be used as a branch of support. PSSs can help young people identify who they can go to for support and what's expected in these relationships—as well as to understand boundaries and awareness of how others may impact their SU and recovery goals.

3.2 | PAS-EPP Practice Toolkit

The PAS-EPP toolkit has six sections based on the PAS-EPP principles and practice domains. See Table 2 for the table of contents. The toolkit includes a brief rationale for each topic and related PSS self-reflection and practice activities. To effectively deliver PAS-EPP, PSSs must understand their personal perceptions of and biases towards substance use, related challenges and SU treatment approaches. The toolkit assumes that PSSs are trained/certified in PSSs principles and practices and have knowledge of transition to adulthood engagement strategies and best practices.

3.3 | PAS-EPP Training

After toolkit completion, PAS-EPP training was designed for (1) CSC teams and (2) CSC PSSs based on the PAS-EPP toolkit and delivered by the research team (Study Coordinator and a PhD-level researcher with experience in PSS and CSC workforce development).

3.3.1 | CSC Team Training

Titled ‘Approaches for Exploring Substance Use as a Coordinated Specialty Care Team’, this 90-min training was delivered virtually to CSC staff (i.e., supervisors, PSSs, supported employment/education specialists, case managers) from 15 Texas mental health agencies. This training introduced the PAS-EPP approach, fostered shared understanding of ways to explore substances with young people and taught strategies for effective and nonjudgemental team collaboration for approaching young people’s substance use from a multidisciplinary perspective.

3.3.2 | PSS Training

‘Peer Approaches to Substances: Training for CSC Peer Providers in Early Psychosis Programs’ was designed to be an immersive, six-hour training for CSC PSSs. PSSs earned CEUs for attendance. The PSS training expanded significantly on topics covered during CSC PAS-EPP team training and focused specifically on practices relevant to the PSS role. Delivered twice to a small group of PSSs ($n = 2$ and 3), training activities and discussions were interactive and designed for participants to share from their lived and living experiences and explore real-life work scenarios together. The PSS training included two 180-min sections (with a 60-min break in between): ‘Navigating Stigma and Intentional Sharing’ and ‘Peer Exploration and Harm Reduction’. Key training objectives included: understanding SU biases, exploring SU without judgement and harm reduction strategies. An expert in SU and Peer Support observed and provided feedback on training alignment with the PAS-EPP toolkit. Training content and activities were then refined.

4 | Discussion

Peer Approaches to Substances for Early Psychosis Programs (PAS-EPP) provides a set of practical self-reflection and practice

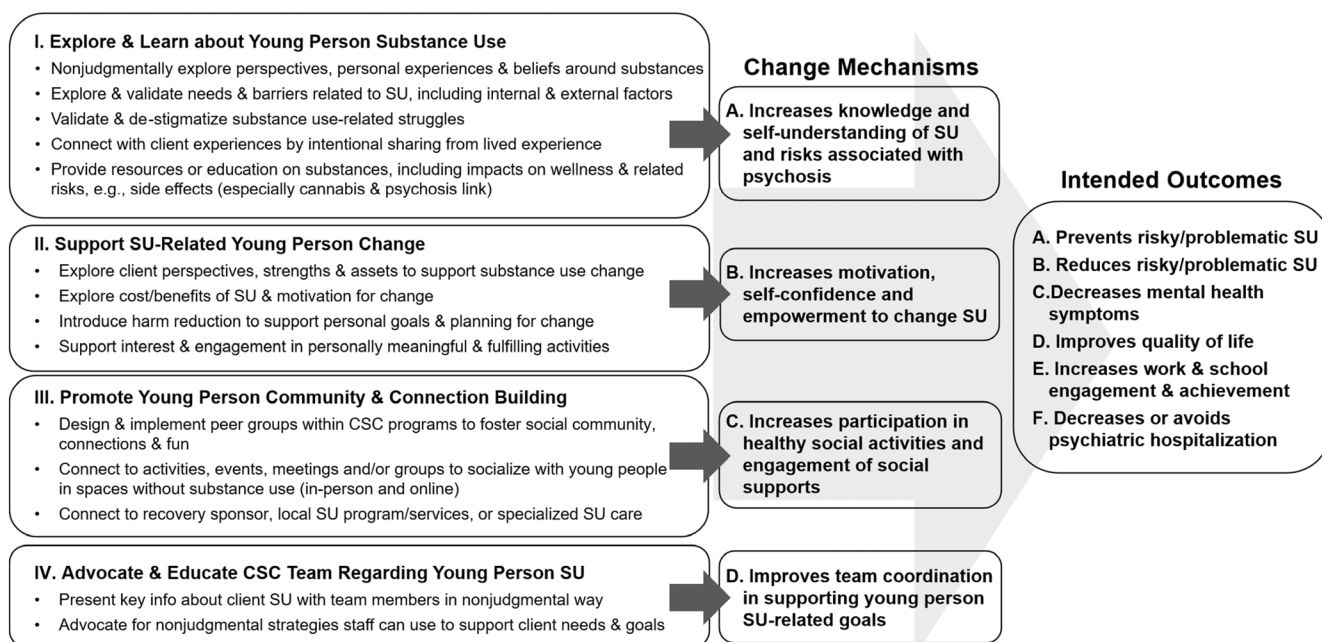


FIGURE 2 | PAS-EPP practice domains, change mechanisms & outcomes.

tools that can be used by CSC PSSs to better approach, explore and support harm reduction around substances with individuals with EP. Peer and lived experience perspectives were integrated in every aspect of PAS-EPP development—from design elements, activities and content refinement to its ideological framework through a co-production process. PAS-EPP can further be used to educate CSC teams and enhance collaboration, understanding and comfort around approaching and supporting client SU as a team. Future evaluation of PAS-EPP for feasibility and impact is important for advancing CSC SU practice.

Importantly as a conceptual distinction, PAS-EPP is not a clinical intervention, but rather a manualised, flexible practice approach designed to guide how CSC PSSs engage with young people around substance use within their defined role. CSC PSSs do not assess, diagnose, or treat substance use disorders. Unlike clinical interventions, PAS-EPP does not prescribe standardised therapeutic techniques, symptom reduction protocols, or clinical decision-making pathways. Instead, PAS-EPP outlines a set of core principles, role-consistent strategies and engagement practices (e.g., lived experience sharing, mutuality, harm reduction) that PSSs can flexibly apply based on a young person's goals, readiness and substance use patterns. This flexibility is intentional and consistent with the broader peer support literature, which emphasises relational, person-centred and non-clinical forms of support rather than manualised treatment (Davidson et al. 2007, 2012).

The development team faced challenges in designing a CSC PSS SU practice approach. The first was to create practical tools not just for CSC clients *diagnosed* with co-occurring SU disorders, but also for CSC clients using substances and not experiencing SU-related negative consequences. Substance use is developmentally and often culturally normative and is tied to socialisation for young people in many communities in the US (Eisenberg et al. 2014). To ensure that the approach was strongly

aligned with PSS practice principles, the approach included exploration of 'why' each individual uses substances in a curious, nonjudgemental way.

Additionally, the approach needed to include guidance on what to do *after* learning about a client's current understanding and perspectives on SU and how it is personally affecting them. There is practice nuance in how to provide information and education about SU-related risks, especially with cannabis and psychosis. Feeling a sense of duty to warn clients of SU consequences based on one's own life experiences and the knowledge that cannabis (and other substances) is strongly tied to psychosis symptom onset and exacerbation can make it difficult to maintain a nonjudgemental or non-directive response to CSC client SU disclosure. A large piece of resolving such tension is building strong working alliances with young people, which is foundational in PSS practice, so that when information is shared (either personal experience/expertise or research/educational), a young person is willing to explore risks and does not become defensive or mistrusting of their PSS.

Another challenge in PAS-EPP development was that to approach client SU in a nonjudgemental way, PSSs had to reflect on, acknowledge and remain aware of the impact of their own experiences and perspectives around SU. Maintaining personal awareness and nonjudgement is challenging because of implicit biases and lived experiences with the use of certain substances. For example, while alcohol and cannabis are generally more accepted for recreational use, methamphetamine and heroin have prevalent negative connotations and social stigma. Each PSS has their own unique experiences with and perspectives about substances and SU—as well as about abstinence, harm reduction, sobriety, treatment and recovery.

PSSs likewise all have unique experiences from which to share (or not share) and explore (or not explore) CSC client experiences.

TABLE 2 | PAS-EPP toolkit table of contents.

Section	PAS-EPP toolkit contents
1. Understanding the Peer Approach	a. Introduction to the PAS-EPP toolkit b. What is the Peer Approach to Substance Use?
2. Stigma & Biases	a. Implicit & Explicit Biases b. 'Moral Neutrality' to Address Stigma & Biases c. Exploring Personal SU Biases: Worksheet
3. Substance Use & the Transition to Adulthood	a. Developmental Impact of Adolescent & Young Adult SU b. 'Normal' SU & Risk Factors for Adolescents & Young Adults
4. Peer Strategies for Exploring Substance Use	a. Exploring the 'Why' b. Normalising SU Experiences c. The Importance of Connection & Peer Working Alliance d. The Impact of Language e. Sharing from Lived Experiences i. Intentional Sharing Guide f. Being Supportive During Uncertainty & Ambivalence g. Goal Development using Wish-Outcome-Obstacle-Plan (WOOP) Exercise (Wittleder et al. 2024) h. Building Support & Community i. Team Collaboration
5. Harm Reduction & the Peer Approach	a. What is Harm Reduction? b. 'Meeting People Where They're At' c. Peer Harm Reduction Strategies i. Guide for Exploring Present Harm ii. Circle of Acceptability Worksheet d. Overdose Prevention (including resources for Naloxone)
6. Overview of Substances & Substance Use Effects	a. What is a Substance? b. Overview of Substances c. Psychosis & Substance Use i. Cannabis & Psychosis: Fact Sheet ii. Psych Meds & Substance Use
7. Appendix	a. Resource List for Peers (Texas & National) b. References

PAS-EPP training materials are helpful for supporting PSS self-reflection and increasing self-awareness to improve one's capacity to withhold judgement and explore client SU in a way that does not reinforce client shame and stigma. CSC PSSs may also benefit from having supervisors trained in PAS-EPP who can support their continued reflection, confidence and competence in supporting young people in exploring substances and meeting their SU-related goals.

Finally, PSSs are part of multidisciplinary CSC teams with several other professionals with varying degrees of SU experience and understanding. PAS-EPP is designed to complement, not replace, CSC services. Effective PAS-EPP implementation requires clear role delineation, supervision structures and communication pathways between PSSs and other CSC roles. PAS-EPP does include guidance and resources for PSSs to share information and insights with their CSC team members regarding client SU, how to share personal perspectives to improve the team's understanding of and empathy for what it is like to navigate both mental health and SU challenges. Some research suggests that PSSs on CSC teams become the de facto SU expert because of their recovery experiences and

sometimes they have both SU and PSS certifications (Klodnick et al. 2024). However, throughout PAS-EPP toolkit and training development, there was consistent recognition that exploring and addressing problematic SU should *not* solely be a PSS's responsibility but must be a coordinated effort of the entire CSC team. More research is needed as to how CSC teams communicate about and collaborate around CSC client substance use and related recovery goals.

4.1 | Next Steps

PAS-EPP is currently being evaluated for feasibility in a mixed-methods study that includes (1) a randomised-controlled trial within the NIH-funded EPINET-TX Learning Health System across multiple CSC providers and (2) in-depth interviews with PSSs, their supervisors and CSC clients in both PAS-EPP and 'usual care' conditions. If found feasible and supportive of potential positive outcomes, PAS-EPP materials will be made publicly available and shared within the EP research. A subsequent trial with a sample size adequate to assess outcomes will also be considered.

4.2 | Limitations

PAS-EPP may not be generalisable beyond Texas CSC programs, as it was designed specifically within and for Texas CSC PSSs. Attitudes towards SU vary greatly across the US. Although the PAS-EPP development team was led by an individual with lived experience, it lacked representation of CSC clients and supporters (e.g., caregivers, family, friends). Furthermore, only one CSC PSS was included on the development team and other CSC providers were not included. This study does not aim to evaluate PAS-EPP implementation and/or impact.

5 | Conclusion

PAS-EPP is an empirically, lived experience and practice-informed approach to young person substance use designed for CSC PSSs. A trial of PAS-EPP implementation is underway to understand its feasibility and impact.

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Disclosure

The authors have nothing to report.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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