



Addiction Recovery and Mental Health Peers Working Together: *Assessment and Recommendations*

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I. Introduction

People with co-occurring mental health conditions and addiction disorders (“co-occurring disorders”) present complex health challenges associated with poor outcomes, (e.g., relapse, homelessness). This is a significant public health problem because substance abuse is the most common comorbid condition among people with serious mental health conditions. In addition, one-third of people with alcohol disorders and one-half of drug users have a psychiatric condition.

Although the evidence supports the need to treat both conditions simultaneously, our systems have typically failed to address these co-occurring conditions successfully. A significant reason is that mental illness and addictions have historically been seen as very different conditions, and mental health and addiction service and support systems have developed independently.¹ People with co-occurring disorders have struggled to navigate the separate care systems, and “practitioners from both fields have been unprepared, and often unwilling, to treat clients from their sister field.” In addition, both addiction and mental health programs have excluded people struggling the condition that “do not work with”, at least until it was “under control.”

New health reform efforts require care coordination, if not integration of care, with a holistic focus on the person rather than just a single diagnosis or program. A significant objective here has been to develop a system where there is “no wrong door”, where specialty providers can effectively treat both conditions or make direct referrals, rather than simply turning people away. Fortunately, there is recognition now that mental health and addictions have much in common. Both have historically been undertreated through acute care deficit based approaches, and the fields are now attempting to shift to a more long-term recovery-based approach.

A particular focus of BRSS-MASS has been on improving the quality of peer recovery services for people with mental health and addiction disorders. In this paper we explore how the addictions and mental health peer movements in Massachusetts have worked well together to address shared concerns. A particular focus has been on effective collaborations between regional addiction “Recovery Support Centers” and the mental health “Recovery Learning Communities”.

¹ Many states have organized their mental health and substance abuse support systems under separate agencies or divisions, each with its own funding mechanisms, job classifications, and criteria for credentials.



II. Background

Peer run recovery organizations are administratively controlled and staffed by peers and offer various “peer” supports, which might include support groups, one-on-one mutual support, community building, advocacy, and social and recreational opportunities. Peer run organizations are evidence-based practices, promoting health and wellness outcomes,² including improvements in quality of life, social support, coping skills, and reductions in hospitalizations.

In Massachusetts, well-established statewide peer-run organizations such as the Transformation Center and MOAR (Massachusetts Organization for Addiction Recovery) have now been complemented by the DMH funded Recovery Learning Communities (RLC) and BSAS funded Recovery Support Centers (RSC). MOAR is a statewide membership association of individuals in recovery, families, and friends educating the public about the value of addiction recovery. The Transformation Center (TC) is the statewide mental health consumer run technical assistance and peer services entity, focused on education and consumer network development.

There are six RLCs, which collectively provide peer recovery support coverage for the entire state. Each RLC is a network whose offerings include (but are not limited to) peer groups, wellness and crisis planning information and referral, and warm line access. Each RLC maintains two to four “recovery connection centers” in its area of coverage, a network offering peer supports in a variety of settings. RLCs provide trainings on self-advocacy, health management, group facilitation, and training leadership. RLCs also assist providers with the integration of recovery orientated practices and peer recovery workers into their services and programs.³

There are also six peer-led RSCs, through which staff and peers exchange knowledge and expertise on non-clinical areas of life, including quality of life, stress management, conflict resolution, parenting, and the job search. A major focus is on providing health and wellness information such as smoking cessation, nutrition, and living with HIV or Hepatitis C, yoga, etc. RSCs use a participatory model, by which peers lead, implement and evaluate center activities, reducing stigma and building relationships with larger community.

III. Methodology, Analytic Framework

The BRSS-MASS Steering committee charged the RC/RLC subcommittee with gaining an understanding of the barriers to and facilitators of addiction recovery and mental health peer collaborations. The subcommittee met several times and recognized the importance of studying high performing collaborations. The western Massachusetts RSC and RLC have been highly recognized for their achievements, and we thank them for the amount of time they gave us. Overall, we took a four pronged approach:

²The Evidence: Consumer Operated Services (2011), p. 32 <http://store.samhsa.gov/shin/content//SMA11-4633CD-DVD/TheEvidence-COSP.pdf>, “Poor quality of care individuals and families with multiple problems receive within the current system of categorically segregated services. That body of research is confirming the superior outcomes achieved within integrated models of care.” Gagne

³ While RLCs receive core funding from DMH, supports are available to all people with mental illness and some are beginning to diversify funding sources.



- 1) Facilitated discussions
 - a. Rene Anderson and Linda Sarage of the Recovery Project, Western Mass. Training Consortium, met with steering committee in October 2012.
 - b. J. Delman met with leadership, staff and members of the Western Mass, RLC and RC in Greenfield, MA for 2 hours
 - c. Transcom (Transformation Committee) meetings and discussion on peers, recovery and behavioral health
 - d. J. Delman met with leadership, staff and members of the Northeast RSC in Lawrence Mass in November, 2012
- 2) Interviews with six key stakeholders: directors of some RCs and RLCs
- 3) Review of the extant literature
- 4) Documents (RFRs, websites et al)

IV. Findings

Massachusetts is a national leader on effective collaborations among mental health and addiction peers. This is seen at two levels: 1) statewide and 2) regionally. Additionally discussed below are a best practice methodology for these groups to collaborate and barriers and facilitators to success.

A. Statewide collaboration

MOAR and the TC have engaged in informative and respectful discussions dating back to 1998⁴, sharing information and collaborating on systems advocacy, and have partnered to apply for a BRSS-TACS grant to provide accurate health reform information to people with mental health and addiction disorders. Recent discussions have taken place in the context of BRSS-MASS steering committee meetings, at BRSS-MASS subcommittee meetings, and in other venues such as at TRANSCOM (state mental health transformation committee) meetings. Additionally, The Interagency Council on Substance Abuse and Prevention⁵ has taken the lead and hosted the BRSS-MASS initiative, facilitating venues for peers to collaborate and share reports on the importance of peer recovery services in all health care settings

The TC and MOAR are small non-profits with somewhat different strategic approaches, making it difficult to fully collaborate on a project. Nevertheless, it has been clear to both organizations that working collaboratively could produce real value, particularly in addressing the recovery needs of people with co-occurring disorders. The BRSS-MASS initiative provided a setting for such collaboration, leading to the above-referenced grant proposal.

⁴ By the time the BRSS-TACS came along, statewide leaders from MOAR, the Transformation Center (TC) and Consumer Quality Initiatives (CQI) have know each other and had easy rapport for over a decade. This was accomplished through several grants and contracts that made room for successful collaborative work and by Connecting at meetings such as the MBHP consumer advisory board, which allowed them to advocate in the same forum.

⁵ Which sits within the Lieutenant Governor's office and consists of the commissioners of relevant state agencies, legislators and private citizens affected by addictions,



B. Regional collaborations: RSCs/RLCs

On a regional level, several RLCs and RSCs have established solid and effective working relationships. Levels of collaboration among the RLCs and RSC have varied by region, in part due to the newness of these program models.

The greatest amount of collaboration has been in Franklin County, between the Recover Center and the Franklin County branch of the western Massachusetts RLC. A key factor to this success was early innovations of Western Massachusetts Training Consortium (WMTC), led Rene Andersen, Associate Director (now an independent consultant), and also a person in recovery from abuse and addiction. In the late 1990s Rene led a ground breaking peer driven approach to violence, trauma and addictions, and in 2003, she led the team that obtained funding from the Center for Substance Abuse Treatment (a division of SAMHSA) to establish the Recover Project. This model⁶ has become both a national model for peer driven recovery supports, and the prototype for the RSC model of BSAS.

WMTC also houses the Western Massachusetts RLC. Having both the RSC and RLC within the same organization establishes shared operational philosophies while reducing potential for “rivalry” issues. The WMTC is an organization that encourages innovation and peer activities, and the initiator of the projects, Rene Andersen is highly respected. Rene has devoted herself to the growth of the Recover Center and its enhanced collaboration, and people trust her as a connecting agent.

Even with this strong infrastructure, there was no one obvious method or clear path to the RLC and RSC to collaborate, given the above-noted philosophical approaches. Thus, the coordinated leadership of the RSC and RLC established used a trial and error approach to seek the most effective collaboration. Although a good deal of what has been tried did not work, the community at large was not fixated on any special approach to collaboration. For example, they at first shared the exact same space, but it became clear that each group wanted its own identity expressed through its space. The RSC and RLC split the space and now reside right next to the other, working collaboratively with a little more distance. Significant methods of collaboration now include regular leadership meetings, a shared advisory board, and support groups generally open to RLC or RSC attendees.

Other RSC/RLC peer collaborations are at an earlier stage of development, Also key for this collaboration was a shared recognition that although peers from each community had different “broad” labels, they were “people first”, with many common experiences (eg, trauma, focus on recovery) that they could bond over, lowering the heat around strong differences of opinion.

⁶ For more detail, see the Western Mass. Training Consortium produced manual: “How to Build Your Own Peer-To-Peer Recovery Center from the Ground Up!” (2006) at <http://www.recoverproject.org/pdf/RecoveryManual.pdf>.



In Lawrence, the RC and RLC also collaborate well, but in a much less integrated way. The RLCs throughout the state train peers to facilitate groups, and the Northeast RLC trains people who attend the RC. The RLC also pays peers to facilitate several groups (co-occurring disorders, arts and crafts) at the RC, and the RLC appreciates the RC's willingness to offer the space. Important components to this collaboration are the recognition of mutual benefit and that at least one person works for the RLC and is a member of the RC.

C. An Appreciative Inquiry Approach to Collaboration: ADPA

As noted in greater detail below (under "philosophical barriers") the addictions and mental health peer communities historically have not been interested in or able to work collaboratively largely because their respective views on the nature of their conditions and the role of peers have not only been very different but in some ways contradictory. . Thus, each group has developed a solid sense of identity, and a political and emotional stake in these respective identities. This has led to a form of identity politics, a defensive stance that blocks communication.

In the United States, these simmering differences have interfered with attempts to collaborate. Thus, the conscious aims of respective leadership must be to see **"collaboration" as not just a process but also as the goal**. Massachusetts peers have done this by leaving behind debate tactics, being open to the "reality" of another person's perspective, and looking for common ground.⁷ Peers participating in dialogues have been internally reflective and have brought such reflections constructively to discussions.

In Massachusetts, we have spelled out this approach to addressing peer community differences in a stepwise fashion:

1) ACKNOWLEDGE 2) DIALOGUE 3) PROCESS 4) ACCEPTANCE

This approach, termed "ADPA" for short, requires representatives of the respective peer groups to respect the differences between their communities, to be self-reflective on their own prejudices, and to sustain some focus on shared values between the groups, ultimately created a strong foundation for future collaborations. When mental health and addictions recovery groups engage, thus the first step is to **acknowledge** that the two groups have some conflicting perspectives on issues of significance, and then define those differences. (These differences are discussed in some detail below.) For example, in our BRSS-TACs group, mental health peers strongly believed that a "peer" worker can only be someone with a mental health condition, while addiction recovery peers tended to believe that "peer" is a broader category that includes at least family and significant others.

During a variety of meetings, the respective peer groups engaged in dialogue to understand a different perspective and the reasons for that perspective. **"Dialogue"** aims to foster empathetic connections in order

⁷ Embodying the Appreciative Inquiry approach, Whitney, D. & Cooperrider, D. (2003). *The power of appreciative inquiry: A practical guide to positive change*. San Francisco: Berrett-Koehler Publishers. <https://positivechange.org/how-we-work/what-is-appreciative-inquiry/>.



to elicit varying perspectives and new ideas.⁸ It is different from a discussion, where people may have prepared thoughts to share and/or perspectives are broken down and deconstructed. Four key essential elements of dialogue are 1) suspending judgment, 2) deep listening, 3) identifying assumptions, and 4) reflection and inquiry.⁹ The dialogue process allows for disagreement but respectfully in a way to develop relationships such that participants naturally connect. To **process** is really the fourth building block of “dialogue”, but we also encourage between meeting processing, which might include self-education on roots and literature of the other group.

After continued dialogue on the definition of “peer”, we didn’t reach consensus, but had a renewed appreciation of the histories of and challenges faced by the other group. As such, it was easy to **accept** this difference and focus on commonalities and methods of collaboration. These kinds of differences were considered in the drafting of our BRSS-MASS systems recommendations, and should be recognized in any movement forward to ensure informed approaches to systems change.

From a programmatic perspective, peer community conflict needs to be addressed in real time. Thus, ADPA should be utilized at program staff levels, since staff perspectives will often reflect and/or impact feelings of the community. In addition, people who facilitate mixed groups should understand and use ADPA. For example, in western Massachusetts, mental health (RLC) peers in a support groups wanted permission to use “respectful swearing”, while RSC peers were opposed. Instead of simply fighting for control of the group, the difference was recognized, leading to separate groups.

D. Barriers and Facilitators to collaboration peer collaboration

BARRIERS

Based on our research, we have identified a cascade of factors that can easily act as barriers to peer community collaborations. Massachusetts peers have taken advantage of facilitating factors to overcome those barriers, though regional RSCs/RLCs continue to struggle with “programmatic” issues. Thus, these barriers fall into two broad categories: 1) programmatic and 2) philosophical/linguistic.

1) Programmatic (RSC/RLC)

RSCs and RLCs generally have reported that it has been difficult to meet to discuss collaboration. Leadership appears to be very booked with potential meeting times typically conflicting.

⁸ Querubin, C. (2011, September). DIALOGUE: CREATING SHARED MEANING AND OTHER BENEFITS FOR BUSINESS. In *Proceedings of the 55th Annual Meeting of the ISSS* (Vol. 55, No. 1).

⁹ Nagda, B., & Gurin, P. (2007). Intergroup Dialogue: A critical-dialogic approach to learning about difference, inequality, and social justice. *New Directions for Teaching and Learning*, 111 (4), 35-45.



One challenge is that RCs and RLCs have different priorities, and collaboration with the other RC/RLC is not prioritized.¹⁰ On top of that, both RSCs and RLCs are relatively new and are continuing in a start-up phase to establish their own identities, operational strategies, and strategic plans. This early establishment and growth phase of course deserves attention, but can take away time from the variety of activities they'd prefer to do. As with many behavioral health programs, the RSCs and RLCs are dealing with tight budgets, and in some cases strategically focusing on areas of potential revenue growth (e.g., LTSS coordination).

A second challenge is geographic; while RLCs have been charged with providing peer coverage at a broad regional level, which ultimately covers the entire state, the six RSCs have been seen as responsible for specific counties/cities. Thus far, successful collaborations have happened between an RSC and one of an RLC's four Resource Connection Centers (RCCs), either county or city (Greenfield, Lawrence).. So at this point, it is only possible for there to be collaborations between an RSC and a local RCC, not something that expands to the entire RLC (i.e., other RCCs), and thus not the state.

Thirdly, RSCs and RLCs have different operational approaches. RSCs are participatory support centers (drop-in), with specific operational rules; most staff activities happen at that one site. With the RLCs, most peer work is expected to take place out in the community, outside of the main office; RLCs are seen as "community support builders", assisting people in developing their internal strength and their natural supports. In addition, RLCs tend to be less rule-driven and more "principle" driven.

2) Philosophical

As noted above, different and seemingly contradictory philosophies and terminologies across the different peer communities have historically interfered with attempts to communicate and thus collaborate (For example, the term "recovery" is now common in both the addictions and mental health communities, but interpretations vary across and within the peer communities. The 12 step model promotes abstinence as an essential element of recovery, simultaneously having insisted that any "mind altering" drug/medication is not acceptable. However, in mental health recovery is not seen as symptom reduction but as community integration and many such people have used medications for their recovery.) The result has historically been difficult discussions about collaboration between the groups, and ultimately no collaboration. Although beyond the scope of this paper, a few illustrations of these differences are worth mentioning.

The mental health consumer movement started as a civil rights movement, outraged by shocking conditions of state hospitals and the misuse of coercive treatment techniques to control patients¹¹. The consumer movement saw that most services tended to label people diagnostically without attending to someone's individualized needs and long-term recovery goals. This impersonal "medical model" focused on "stability"

¹⁰ RLC and RC state contracts have not emphasized RC/RLC collaborations. The focus has been on working within and around an existing and exclusive system of care. RLC contracts for example have emphasized collaborations with mental health providers, as well as shelters and similar entities.

¹¹ Such advocates engaged in community organizing and direct action to protest, insisting on reform and a peer run solution



and first line medication use was contrasted with the desired recovery oriented approach- person-centered, trauma informed, strengths-based, and peer driven. As a result of these deficiencies, mental health peers became visible and at times aggressive activists. In contrast, the addictions peer movement has largely been built around the “mutual aid” 12 step approach (e.g., AA), insisting on anonymity for people in recovery. Although concerned with the professionalization of addiction services, there has not been a great focus on changing that model, instead building the alternative, or complementary, model of mutual aid.

Another major difference is the role of peer recovery workers. The mental health peer movement established the (certified) Peer Specialist (CPS) role, and many members believe that CPS employment on treatment teams as essential, to both enhance the recovery potential of many clients and influence provider culture. Peer Specialists have sought professional status and growth through a certification process¹². On the other hand, it is well-established that many workers in the addictions field are in recovery, and clients (and other stakeholders) are aware of that generally without there being a formal declaration. That is, many clients who of service workers become aware that the person is in recovery, Many people in addictions thus wonder why there needs to be a defined peer position, perhaps as Recovery Coaches. In fact, anonymity is a critical value in peer culture.

FACILITATORS

More than any other place, Massachusetts has served as an excellent environment for mental health and addictions peer collaborations. Here is what it seems to take:

- 1) Peer Communities address differences utilizing the ADPA approach:
Acknowledge Dialogue Process Acceptance

See page four. In addition, Rene Anderson has recommended that people will more successfully engage in such a process when they have received general “Diversity training”.

- 2) Effective Leadership Priorotizing Collaboration

In any serious systems effort, group leaders set the tone for others by modelling collaboration and by seeking resources to support it.. Leaders are people who often have obtained resources to support peer work and are respected by their consituency. Good leaders devote themeselves to a mission, work in teams, and maintain their belief system while being open-minded to other perspectives.

¹² PS certification became popular because in some state that role can be Medicaid reimbursed (not Massachusetts). In Massachusetts, CPS training and certification also serves as designation that a person has demonstrated the skills and abilities of a Peer Specialist through an examination process. Some Peer Specialists are in organizational leadership positions and others have moved on to other provider roles.



3) Building from Positive Relationships

By the time the BRSS-TACS grant opportunity came along, statewide leaders from MOAR and the TC had known each other with easy rapport for over a decade. On a regional level, in western Mass., a leader in both communities for years has been Rene Andersen, who has devoted herself to the growth of the Recovery Center and its enhanced collaboration with the RLC. She is a trusted change agent with a very clear philosophical approach.

4) Trial and Error approach

There is no absolute manner for the peer communities to work together, as collaboration best practices are new and still being assessed.

5) Work from Commonalities

There should be a conscious choice to work from commonalities, which may vary per group. Although there may not be agreement on what “recovery” means, there can be agreement that recovery is both the approach and the aim. There is agreement that that people have an inner capacity to attain wellness, and that with recovery oriented help can be effective parents, spouses, workers. In addition, both communities share in the recognition that peers are a vital component of recovery. In these cases, it is the general notions that count, not the detailed differences, which can later be explored through ADPA approach.

The strongest commonality recognized in Western Massachusetts is the frequent and significant role that trauma plays in impacting a person’s overall health.. This is supported by research evidence (ACE study) and has validity, particularly with the recognition of child sex abuse scandals.

Another point, of full agreement, is an emphasis on wellness and public health (see Delman article), ranging from addressing co-morbid medical conditions to prevention through fitness, weight-watching, smoking abatement, and nutrition monitoring.

There is an emerging agreement between fields that consumer choice of treatments, programs etc. is very important to achieving “recovery” and wellness.

V. Recommended Facilitative tools of collaboration

Examples of peer collaboration building blocks, even if leadership meetings are difficult to schedule:

- 1) Addiction and MH peer agencies establish a co-council
- 2) Cross-training: groups present workshops to the other
- 3) Work through a strong connecting person, a person respected in both peer agencies/communities
- 4) Work from proximity (eg., nearby offices).... Regular staff contact



- 5) Study the background and philosophies of the other peer group
- 6) Share a website link that permits a visitor to choose which program is better for his/her (ie developing a one-stop approach)
- 7) Work on short-term projects together, such as a collaborative workshop or developing a shared training module (Look for things in common to address- housing, employment, trauma)
- 8) Serve on an advisory board together and collaborate on shared recommendations
- 9) For programs, hold a support group at the other program