Bringing Massachusetts' Recovery Supports to Scale
Moving Towards a Recovery-Oriented System

Final Draft

Our Progress and Recommendations for Future Sustainability

A Department of Public Health and the Department of Mental Health Collaboration

Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA)

A Letter to Partners in Change

Dear Partners in Change:

The Affordable Care Act mandates sweeping changes in the delivery of health care in the United States. Within the Commonwealth, new models of care and payment reform strategies are being designed and implemented to control costs while improving access and care. Efforts to fully integrate care are well underway, but there is a need to closely examine integrated care models that can provide effective, recovery-oriented care services to people with serious mental health and addiction disorders. This population experiences high levels of co-morbid physical conditions and poverty, as well as stigma associated with them. The rates of this population's preventable ER and hospital use are unreasonably high, resulting in poor health outcomes and very high costs of care. Recovery-oriented care mitigates this problem through the provision of services that are person-centered, support multiple paths to recovery, and focus on a person's strengths.

In recognition of these issues, SAMHSA funded to several states, including Massachusetts, to "bring recovery supports to scale." We are grateful for this opportunity, which has allowed us to build from prior successful collaborations among state agencies, providers, and people with the lived experience of mental health and/or addiction recovery to advance the conversation. Having now completed our environmental assessment and report, these various groups have collaborated to prepare a pathway forward for the Commonwealth and other key stakeholders.

This report details a strategy for many stakeholders to be agents of change for the provision of well-coordinated, recovery-oriented, and evidence-based support to be delivered in the new models of care. Peer Specialists and Recovery Coaches have demonstrated success with using their lived experience to help people develop hope and assume actions that will lead to recovery, including taking advantage of the full array of community-based services and use of natural supports. This project has shed light on the importance of expanding opportunities for peer recovery supports while also spotlighting the power of collaboration between the mental health and addiction peer communities. Addressing perhaps the most complex condition, co-occurring disorders, is critical for public health, and these two peer communities have invested tremendous energy and time with this goal in mind.

As the Executive Director of the Interagency Council on Substance Abuse and Prevention and the team leader of this endeavor, all of the hard work invested by the multiple partners engaged in this project is greatly appreciated. The team is excited to see its recommendations inform many health care reform efforts, existing and into the future. We look forward to "bringing recovery supports to scale" with all of you.

Sincerely,

William D. Luzier
Executive Director, Interagency Council on Substance Abuse and Prevention

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Acknowledgements

Our Policy Academy members would like to formally thank the Substance Abuse and Mental Health Services Administration for the opportunity to work in partnership to bring recovery supports to scale in Massachusetts. We thank the Interagency Council on Substance Abuse and Prevention and the Legislative Joint Committee on Mental Health and Substance Abuse for their commitment to this project and in sharing of a common goal to refine and expand recovery support services. We would like to recognize the work of our Steering Committee (See Appendix A for a list of Steering Committee Members), more specifically their commitment to meet routinely, participate in workgroups, provide guidance, and develop recommendations. We would also like to recognize the commitment received from our state partners from the Executive Office for Health and Human Services, Bureau of Substance Abuse Services within the Department of Public Health, Department of Mental Health, and Office of Medicaid. These partnerships are critical to the identification of feasible methods for implementing best practices and policy recommendations.

This project would not have been possible without the passion and commitment demonstrated consistently by our community partners, including MOAR (Massachusetts Organization for Addiction Recovery), The Transformation Center, and many of the local peer run-recovery organizations. We also appreciate the continual educational insights of our academic partner, the University of Massachusetts Medical School, Department of Psychiatry, which worked collaboratively with us to better understand and improve mental health and addictions services. Most importantly, it has been the work of individual Certified Peer Specialists, Recovery Coaches, and Recovery Education Facilitators who identified challenges and solutions during subcommittee work that made the project results so meaningful. We thank you for your attendance to each and every meeting. Your honest insights and dedication to collaborate across the mental health and addictions communities will ultimately bring recovery supports to scale within the Commonwealth.

Finally, we would like to recognize that significant portions of this report are informed by previous and parallel policy efforts, including the work of Transcom and the development of the Policy Academy's formal comments on the Commonwealth's Comprehensive Primary Care Payment Reform (provided in the fall of 2012).

Executive Summary

Background: In 2012, the Massachusetts' Interagency Council on Substance Abuse and Prevention received a SAMHSA grant award to support an interagency, community-connected Steering Committee that would develop a plan to incorporate the mental health and addictions recovery models into the developing models of integrated health care such as health homes ("BRSS-MASS"[1]). The strategic aims of BRSS-MASS were to 1) increase the number and quality of "peer recovery support services"[2], evidence supported interventions provided by people in recovery, who would also act as agents of organizational recovery transformation, and 2) enhance the capacity for mental health and addiction recovery communities to work collaboratively, recognizing the specific needs of people with co-occurring (mental health and addiction) disorders.

The recovery model aims to help people with mental health and/or addiction disorders attain a valued role in society, and is based on a set of principles including that care be person-driven, trauma-informed, strengths-based, and supported by peer recovery workers. Peer recovery workers (PRWs) are people in recovery from mental health and/or addictions issues who use self-disclosure to provide people with direct emotional support, aid in developing a recovery plan, and help navigating the health system. These roles are generally integrated into treatment teams, including health centers, inpatient and outpatient settings, emergency rooms, and crisis centers. Several hundred of these positions exist in Massachusetts, primarily funded by DMH and BSAS.

PRW Training: In mental health PRWs are typically called "Peer Specialists", who become "certified" through formal training and demonstration of critical competencies by passing an oral and written exam. In addictions PRWs are called Recovery Coaches, who attend the Recovery Coach Academy (RCA) training. The trainings are funded by DMH and BSAS respectively. A subcommittee of the steering committee examined the commonalities of and differences between the Certified Peer Specialist and Recovery Coach training teams, which are now planning to share some modules while collaboratively developing enhanced trainings (eg. Supports for people with co-occurring disorders), based on the following recommendations:

1. Address the need for universal accessibility, inclusion, and cultural competence first and throughout all training work.
2. Invite and explore continued partnerships and solidify our commitment for mental health and addiction recovery community members to work together to improve the quality and integration of peer worker training.
3. Develop a workforce development plan in collaboration with the Training Subcommittee to confirm/conduct specific training projects that improve the overall quality and coordination of peer worker training within the Commonwealth.
4. Improve Training Content and Processes
5. Support the Creation of Experience-Based Peer Worker Career Ladders

Peer-run recovery organizations are administratively controlled and staffed by peers with lived experience, and provide one or more of the following: mutual support, community building, system advocacy, service provision, advocacy, assistance with basic needs or benefit, and social and recreational opportunities. Historically, various philosophical and operational differences have prevented mental health and addiction recovery peer communities from working together. However, peers from both communities in Massachusetts have taken a national lead in establishing a strong collaboration through both PRW training (above) and

[1] Bringing Recovery Supports to Scale- Massachusetts.

[2] "Peer Recovery Support Services" (Peer services) are non-clinical recovery supports provided by people with the "lived experience" of a psychiatric disability and/or addictions disorder who have an empathetic perspective and unique skills

organizationally, both regionally and statewide. The respective statewide technical assistance and advocacy organizations, MOAR (Massachusetts Organized for Addictions Recovery) and the Transformation Center, have been in discussions for over a decade, and have become more formally collaborative through the BRSS-MASS grant.

Regionally *Recovery Learning Communities (RLCs)* are regional technical assistance that are run and staffed by people with the lived experience of a serious mental health conditions, and six are funded by DMH. RLCS offer a wide variety of peer support, peer education and public education activities. *Recovery Centers (RCs)* provide opportunities for people in addictions recovery to provide peer-driven activities which create opportunities to learn new skills, mentor others, and value one's lived-experience, and six are funded by BSAS. RC and RLC peer leaders have been successful in working together despite philosophical and linguistic differences, because leadership and colleagues have led and modeled civil dialogue, respected those differences, were self-reflective, and worked from commonalities, finding collaborative activities with a clear goal (eg., holding a peer group at the other center).

Co-occurring disorders: People who have both mental health and addiction disorders, in effect "co-occurring disorders", face very poor outcomes, including high rates of relapse, homelessness, and criminal activity. Because mental illness and addictions have historically been seen as very different conditions, practitioners have generally attached themselves to only of the fields, and have been unprepared, and often unwilling, to treat persons from the disorder they are unfamiliar with. Both communities (through this project) have validated existing research and the need for persons with co-occurring disorders to be treated simultaneously and supported by mental health and addictions providers and peer recovery services.

Steering Committee Broad scale Recommendations (with specifics to be found in the body of the report)

1. **Recognize Peer Specialists and Recovery Coaches as essential, foundational elements of existing and developing models of health care delivery**
2. **Through the new models of integrated care, develop a comprehensive, recovery-focused system of care for people with co-occurring mental health and addiction disorders**
3. **Sustain and improve the quality of peer recovery supports within the Commonwealth, including peer-run recovery centers and communities**
4. **Support the establishment of policies for the successful integration of peer workers and Recovery Coaches in all health care delivery models.**
5. **Develop a peer workforce that is culturally competent and representative of the communities being served.**

Final Report

Introduction

Approximately 26.2 percent or 57.7 million people ages eighteen and older—about one in four adults—suffer from a diagnosable mental health disability in a given year.[3] In addition, 8.7 percent of the population aged 12 or older, or an estimated 22.1 million people, were classified with substance dependence or abuse in the past year.[4] A total of 8.9 million have co-occurring substance abuse and mental health conditions.[5] Moreover, studies suggest that approximately half of individuals with mental health conditions also have accompanying substance use (and 70% smoke), resulting in medically-related problems including mortality rates 25 years younger than those without a co-occurring disorder.[6] Individuals with serious physical health problems often have co-morbid behavioral health challenges, and nearly half of those with any mental health disability meet the criteria for two or more disorders.[7] Given these numbers, there is increasing acknowledgment that behavioral health disorders are the leading cause of disability, lost productivity, and premature death.[8]

Recovery is a "process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."[9] Recovery outcomes for people with serious behavioral health disorders include the capacity to successfully manage their complex health conditions and integration to community life through the development of stronger social networks, inspired hope, and the utilization of preferred self-management skills. Recovery is possible for many people when they are served within recovery-oriented systems of care. Recovery-oriented care is strengths-based, person-centered, and community-based. "Recovery oriented services" build upon each person's strengths to support their active participation in selecting services and developing treatment plans, their development of self-management skills, and obtaining a meaningful role within the broader community. (Traditional services have focused primarily on a person's "deficits", such as symptoms and poor work skills.) In a complex health system aimed at integrating primary care and behavioral health enhancing access, improving health outcomes, and controlling costs, **peer recovery supports should be regarded as an essential, required element of an effective health care system.**

Based on over 22 studies of peer recovery supports reported in the literature (including randomized trials) the research demonstrates that peer specialist services improve outcomes, including reductions in

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[3] Kessler RC, Chiu WT, Demler O, Walters EE. (2005). Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). Archives of General Psychiatry, 62(6):617-27.
[4] Substance Abuse and Mental Health Services Administration, Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-41, HHS Publication No. (SMA) 11-4658. Rockville, MD,, 2011.
[5] Substance Abuse and Mental Health Services Administration, Office of Applied Studies, National Survey on Drug Use and Health, 2008 and 2009.
[6] Hall SM, Prochaska JJ. T (2009) treatment of smokers with co-occurring disorders: emphasis on integration in mental health and addiction treatment settings. Annual Rev. Clinical Psychology, 5:409-31.
[7] Id at (1)
[8] Colton CW, Manderscheid RW (2006). Congruencies in increased mortality rates, years of potential life lost and causes of death among public mental health clients in eight states. Prev. Chronic. 3:April (online only). (Accessed February 21, 2013, at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1563985/).
[9] Substance Abuse and Mental Health Services Administration, Working Definition of Recovery (Updated), March, 2012, http://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated/.

hospitalization, improved social functioning, and reduced substance abuse.[10] In addition, studies show that peer workers can be agents of change in promoting recovery oriented services.[11] For example, people with behavioral health conditions have been active participants in all aspects of preparing the BRSS-TACS grant proposal and have continued their involvement in order to achieve the stated goals.

Thus, in 2011, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) introduced a national initiative: Bringing Recovery Supports to Scale Technical Assistance Center Strategy (or "BRSS-TACS"). Given existing payment reform and the broad implications of the Affordable Care Act for the Commonwealth, BRSS-TACS funding (awarded to the Commonwealth in 2012) has provided an opportunity to increase awareness and build upon existing peer recovery services that exist within our mental health and addictions systems, ultimately ensuring the timely inclusion of peer recovery concepts into health care and payment reform efforts.

Massachusetts BRSS-TACS Vision Statement

A Commonwealth in which behavioral and primary health care services 1) are peer informed, directed and/or provided, 2) support and promote wellness, recovery, and choice, and 3) are culturally and linguistically competent.

Overview of the BRSS-TACS Initiative

The goal of the national BRSS-TACS initiative is for "people in recovery from *mental and substance use disorders to* guide the behavioral health system and promote individual-, program-, and system-level approaches that foster health and resilience…" In 2012, the Massachusetts' Interagency Council on Substance Abuse and Prevention, the project's sponsor, received a SAMHSA award to participate in a BRSS-TACS-sponsored Policy Academy. The purpose was to develop a plan to bring "recovery supports to scale" in Massachusetts by identifying, designing and implementing strategic policies, financing mechanisms, and/or infrastructure improvements for 1) increasing the number and quality of peer services; 2) identifying and implementing methodologies for the mental health and addiction recovery communities to work collaboratively; and 3) developing a plan and recommendations to bring recovery to existing and new models of care while addressing the needs of people with co-occurring (mental health and addiction) disorders. As a result, a Steering Committee, made up largely of state government and peer leaders, was formed. (Please see Appendix A for a list of Steering Committee members.)

Steering Committee members joined other states at a BRSS-TACS Policy Academy event in April, 2012 in Washington DC. The Massachusetts team participated in a variety of planning activities and created a vision statement for people with behavioral health needs. We created a six month project plan that builds on the existing infrastructure of peer recovery services and cross-stakeholder partnerships, maximizing coordination

[10]See egs., Cook JA, Copeland ME, Jonikas JA, Hamilton MM, et al (2012) Results of a randomized controlled trial of mental illness self-management using Wellness Recovery Action Planning. Schizophrenia Bull. 38(4):881-891 (Receipt of peer delivered Wellness Recovery Action Plan (WRAP) in relation to treatment as usual produced statistically significant reduction in symptom severity, greater sense of hopefulness, higher quality of life, and improved self-advocacy);

Davidson L, Bellamy C, Guy K, Miller R. (2012). Peer support among persons with severe mental illnesses: a review of evidence and experience. World Psychiatry 11:123–28.

[11] Janzen, R., Nelson, G., Trainor, J., & Ochocka, J. (2006). A longitudinal study of mental health consumer/survivor initiatives: Part IV – Benefits beyond the self? A quantitative and qualitative study of system-level activities and impacts. Journal of Community Psychology, 34, 285–303.

across state agencies. This project has provided the opportunity for the peer communities to work side-by-side with state leaders and academic partners to identify the challenges of and concrete solutions to breaking down existing silos to provide high quality recovery oriented services. We emphasize our commitment to addressing need differences based on age, gender, disability, race, ethnicity, historical experience, and chosen path to recovery.

A sample of activities implemented include holding routine leadership meetings to discuss pertinent projects and events, inventorying existing Massachusetts peer services, and engaging in subcommittees regarding specific topics of interest . This report provides results of our analysis and lessons learned. Our recommendations, set forth later within this report, are intended to be an initial step towards developing a comprehensive *Transformation to a Recovery-Oriented System* plan for bringing recovery supports to scale in Massachusetts.

Recognizing Uniqueness as a Foundation for Mental Health and Addiction Recovery Peer Collaborations

Massachusetts has taken a national lead in furthering the discussion between mental health peers with lived experience and addiction recovery peers with lived experience on their collective uniqueness and commonalities. Nationally, these groups historically have had significant differences that have impeded collaboration. Each group's unique historical formation has strongly influenced its distinct ideas on "recovery", roles for peer workers, and advocacy style.[12] Addressing the significant differences between these unique interest groups through dialogue is critical for building a foundation for ongoing collaboration, identifying existing resources, and sharing desired goals for systems change.

One significant area of difference that highlights the potential for poor communication relates to the very different perspectives on the role of the peer worker. The mental health peer movement has sought and established the Peer Specialist role, an essential and paid member of provider organizations and treatment teams. Peer Specialists have sought professional status and growth through the creation of a recognized certification process[13], and see themselves as prepared to influence provider culture and ultimately practice. On the other hand, addiction recovery peers know that a majority of addictions staff are people in recovery, and see no need for reserving a specific job title for identified peers (i.e., "peer" Recovery Coaches). In fact, anonymity is a critical value in addictions peer culture. In addition, many within the addictions peer community believe that the provision of peer support is a service they give back to the community without payment. And while a mental health "peer" is someone with the personal "lived experience" of mental illness, the addictions community has a variety of perspectives on what a peer is, including members and loved ones with their own lived experiences

[12] With regard to historical formation, the mental health consumer movement started as a civil rights movement, outraged by the poor conditions of state hospitals and the misuse of coercive methods of "treatment". Much advocacy has taken the form of open and direct action, such as protests, against a system that impeded recovery. In contrast, the addictions system of care was originally created and implemented by peers with lived experience, and as a result, the peer role has been an integral part of the system, sometimes indistinguishable from other parts. The dominant peer movement in addictions is focused on the vital role of mutual aid (e.g., AA), a support model based on anonymity and the helper principle.

[13] Certification became popular in some states as peer specialist services became Medicaid reimbursable (this is not the case in Massachusetts). In Massachusetts, CPS training and certification serve as a designation that a person has demonstrated the skills and abilities of a Peer Specialist through an examination process.

Largely driven by a strong sense of purpose to collaborate, Massachusetts mental health and addiction leaders with lived experience, both before and after this initiative, have taken an "Acknowledge [differences], Dialogue, Process, and Accept" (ADPA) approach**,** which embodies the principles of the "Appreciative Inquiry[14]" (See Appendix C for more detail on this approach). As a result, there has been consistent reflection on similarities and differences in peer activities and their relative systems. As with any such discussions, individuals participating had to be internally reflective and bring such reflections constructively to the discussion. Many of the main points recognized through this process are described below. These points, among others,[15] were considered in the drafting of recommendations and should be recognized in any movement forward to ensure informed approaches to systems change.

The Existing Role of Peer Support Services

"Peer Recovery Support Services" are non-clinical recovery supports provided by people with the "lived experience" of a psychiatric disability and/or addictions disorder who have an empathetic perspective and unique skills. With peer support, people share common concerns or problems and provide emotional support and coping strategies to manage and promote personal well-being. Peer services offer a powerful message that recovery is possible both to services providers and to clients. Examples of services peers include chronic illness self-management, whole health and wellness promotion and engagement, relapse prevention, life skill coaching, connection to resources for employment and housing, and insurance and health systems navigation. Peer Recovery Support Services help individuals and families initiate, stabilize and sustain recovery. As an evidence-based model, Peer Support Services have been demonstrated to promote positive health outcomes and control the cost of healthcare.

> *"Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders. CMS recognizes that the experiences of peer support providers, as consumers of mental health and substance use services, can be an important component in a State's delivery of effective treatment. CMS is reaffirming its commitment to State flexibility, increased innovation, consumer choice, self-direction, recovery, and consumer protection through approval of these services."* CMS SMDL No. 07-011 letter (2007).

There are two broad mechanisms of peer support services: 1) peer-run recovery organizations and 2) peer recovery workers. Both are described in more detail below.

Peer-Run Recovery Organizations

Peer-run recovery organizations are administratively controlled and staffed by peers with lived experience, as well as provide one or more of the following: mutual support, community building, system advocacy, service provision, advocacy, assistance with basic needs or benefit, and social and recreational opportunities. According to the SAMHSA report, "The Evidence: Consumer Operated Services" (2011), "Evidence shows that

[14] Whitney, D. & Cooperrider, D. (2003). The power of appreciative inquiry: A practical guide to positive change. San Francisco: Berett-Koehler Publishers.

[15] See Appendix B for additional commonalities and differences highlighted through this project.

consumer-operated services are supporting people in their wellness and recovery while also contributing to the entire mental health service system." (p. 32). Evidence supported outcomes include but are not limited to: improvements in quality of life, social support, coping skills, and reductions in hospitalizations.[16] Beneficial outcomes based on Peer Specialist services include reductions in hospitalization, improved social functioning and reduced substance abuse for the recipient, and improved recovery outcomes for the peer specialist.[17]

Mental Health

The Transformation Center (TC), the statewide consumer run technical assistance and peer services entity, has consistently received SAMHSA state networking grants, and through those grants developed consumer networks of both Hispanic and Deaf & Hard of Hearing consumers, leading the nation in the peer diversity. The TC has also worked with the state to establish statewide networks of African American consumers and young adults with mental health conditions. Currently the TC is working with DMH on the development of training for non-peer supervisors of Certified Peer Specialists. In 2005, the Office of Medicaid received a Real Choice System Change Mental Health System Transformation Grant from the Centers for Medicare and Medicaid Services (CMS), through which Department of Mental Health and the Office of Medicaid worked with the TC and others to establish a certified Peer Specialist program (a type of peer recovery worker described below).

As part of the CMS grant, Transcom, with TC and the Department of Mental Health taking the lead, developed the Recovery Learning Community (RLC) concept. RLCs are regional technical assistance organizations that are run and staffed by peers, people with the lived experience of a serious mental health condition. RLCS offer a wide variety of peer support, peer education and public education. WRAP (Wellness Recovery Action planning) is the most common type of peer education, in which certified WRAP trainers in group sessions guide consumers to develop their own planed responses to signs and difficulties that may lead to a crisis and to develop supports that lead to long-term recovery. Peer education also includes alternative healing opportunities (e.g. yoga). The RLCs have also played a major role in assisting providers with the integration of peers and recovery orientation into their programs. There are now six RLCs covering the entire state, and they are fully Department of Mental Health funded. Each RLC has four Recovery Resource Connection Centers, which offers a variety of peer supports, including peer support by phone and in person, computer labs, libraries and, community meetings.

Addictions

MOAR, Massachusetts Organization for Addiction Recovery, is a statewide membership association of individuals in recovery, families, and friends educating the public about the value of addiction recovery. MOAR has a peer driven and facilitated curriculum to help individuals and families navigate the system, building leaders for and in recovery.

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[16] http://store.samhsa.gov/shin/content/SMA11-4633CD-DVD/TheEvidence-COSP.pdf

[17] Cook et al, 2012, Davidson et al, 2012; Moran, G., Russinova, Z., Gidugu, V., Yim, J. Y., & Sprague, C. (2012). Benefits and mechanisms of recovery among peer providers with psychiatric illnesses. Qualitative Health Research, 22(3), 304–319.

In addition, BSAS has funded six regional peer-led Recovery Centers (RCs), which provide opportunities for peers to initiate, design, create, implement, and evaluate center activities and policies and provide peer-driven activities which create opportunities to learn new skills, mentor others, and value one's lived-experience. Peers also engage in community building by reducing stigma, building relationships with the greater community, and putting a positive face on recovery. The Recovery Centers demonstrate that lived experience is valued and valuable to the greater community and include mentoring, coaching, and peer-led support groups & activities, etc. Center attendees can learn from peers new knowledge, information, and/or skills to enhance one's well-being. Examples include parenting skills, stress management techniques, conflict resolution, job search training, educational resources, and health and wellness action such as smoking cessation, nutrition, living with HIV or Hep C, and yoga. Peers also provide concrete assistance in helping others do things or get things done. Examples include transportation, child-care, clothing exchanges, guidance/assistance with filling out benefits applications or helping people obtain entitlements and find resources that help support their recovery.

Peer Recovery Workers

Peer recovery workers provide direct emotional support, using their lived experience through self-disclosure to others in a structured way. According to the Centers for Medicated and Medicare Services, *"Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders. CMS recognizes that the experiences of peer support providers, as consumers of mental health and substance use services, can be an important component in a State's delivery of effective treatment."*[18]

In part because of historical differences, the terminologies and types of peer roles in mental health and addictions differ, as discussed above.

Mental Health

Peer Recovery worker is a general term applying to people with a lived experience of mental illness who are empathetic and provide direct emotional support for a consumer. Based on a recent survey of peer services in Massachusetts [FN], we learned that there are generally five types of PRWs: 1) Peer Specialist, 2) Peer Support worker, 3) Peer Facilitators, 4) Peer educators, and 5) Peer Supervisors.

"Peer Specialists" are experienced PRWs who share their recovery stories and other knowledge in an inspirational way with consumers to support their "regaining balance and control of their lives, and to support recovery."[19] These roles are generally integrated into treatment teams, including mental health centers, inpatient and outpatient settings, emergency rooms, and crisis centers.[20] The service is a non-clinical structured and scheduled rehabilitative activity provided by a trained and certified person who self-identifies

[18] Letter to State Medicaid Directors No. 07-011. August 15, 2007. Retrieved February 21, 2013 from http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD081507A.pdf.

[19] Chinman, M., Young, A. S., Hassell, J., & Davidson, L. (2006). Toward the implementation of mental health consumer provider services. Journal of Behavioral Health Services & Research, 33(2), 176–195.

[20] Fricks, L. (2005). Building a Foundation for Recovery: A Community Education Guide on Establishing Medicaid-Funded Peer Support Services and a Trained Peer Workforce. DHHS Pub. No. (SMA) 05-8089. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2005.

as currently or formerly using mental health services, and skillfully uses his/her lived experience as a primary tool.[21]

Our survey found that from a provider's perspective Peer Specialists are serving three main functions: 1) Assist and support consumer to set and achieve recovery goals, in part by supporting the consumer's participation in developing their treatment/service plan and advocating for the consumer as necessary, 2) Assist and support consumer to navigate system of services and supports, including consumer education on the various services and treatment options available, 3) Facilitate peer support groups. Many Peer Specialists also help consumers reintegrate into the community, participate in treatment team meetings, and educate program/agency about "recovery-oriented" approach. Some even advocate the program/agency to enhance its recovery-oriented practices and develop/expand available recovery support resources. Many Peer Specialists now receive specialized training and are employed in care teams that provide services for difficult to reach populations, such people who have criminal court involvement, people who are homeless, people who are deaf, and people of various cultural and ethnic minorities.

The term "Peer Specialist" has also become a professional designation because the position requires minimum levels of education, experience, and training, and an allegiance to a known code of ethics. **Certified Peer Specialists (CPS)** have received formal training in using their experience to engage another person in the recovery process and demonstrate critical competencies by passing an oral and written exam. The designated certification training and certification body in Massachusetts is The Transformation Center [only state peer run certification[22]]. The CPS training program has been fully funded by DMH. The training and certification process has led to over 350 CPSs certified. Many also maintain their knowledge and skill base by completing annual continuing education units.

PSs and CPSs are now formally recognized as integral members of clinical and non-clinical teams funded by both DMH contracts and the Medicaid carve-out, the Massachusetts Behavioral Health Partnership (MBHP). They work in the mental health system, most prominently in Community Based Flexible Supports, Programs for Assertive Community Treatment (PACT), Emergency Service teams and as hospital Peer Bridgers.

A second type of PRW role is the "**peer support worker**" who advises and/or supports a consumer though not necessarily in a way that ties directly to recovery goals. One example is peer de-briefers, who counsel and support a (hospitalized) patient shortly after they have had seclusion and/or restraint experience. Both DMH and the RLCs have peer employees that support consumers to become more active in committees and policy bodies. Young adult peer mentors are being hired in increasing numbers at DMH youth residential programs, employment programs. DMH has supported the development of a young adult peer mentoring curriculum that is currently being worked on by the TC (Lyn Legere) and young adult leaders.

A third category of PSWs are **peer group facilitators**, whose primary role is to conduct peer support groups. Many groups happen through voluntary efforts, particularly those of DBSA. In addition, groups now flourish under the auspices of RLCs, facilitated by staff or community members who have been trained to facilitate (Through the 6 RLCS, there may be approximately 90 support groups per week occurring).

[21] Transcom, Status of the Developing Mental Health Peer Workforce in Massachusetts: 2012 update

[22] The Transformation Center is the only peer run organization that offers these trainings and assesses competencies for certification.

A fourth category of PRWs are **peer educators**, who can educate consumers individually or in groups, such as WRAP. Another growing form of peer education is "Peer Support Whole Health & Resiliency (PSWHR)" planning, through which consumers are taught about maintaining (whole) healthy and resilient lifestyle (with a focus on nutrition and physical activity) and specifically to set, get and keep a specific whole health/resiliency goal.

Finally, peer supervisors not only provide peer support services but oversee the provision of peer services within a program or agency wide. Through our survey we have learned that many peers now serve in senior management levels of provider agencies, offering advice not only on the development of a peer services workforce, but also on providing recovery oriented services.

Through our survey we were not able to achieve a sample size sufficient to truly approximate the number of PRWs, except to say that there are many hundreds in both full-time and part-time roles. The driving force here has been the implementation of CBFS services, with 52 CBFS teams statewide. Our survey sample of 21 CBFS team responses showed that Peer Specialist FTEs per team ranged from .5 to 4, with a median of 2. (According to a recent DMH report, responding agencies had an average of 7 peer workers.) Aside from peer supervisors, peer support workers' hourly wage generally ranged from $10-20 per hour, most typically between $12-14 per hour but also commonly from $17-20 per hour.

Addictions

As noted, Peer Recovery Coaches work within the addictions treatment system with individuals and families seeking to initiate, achieve and sustain long-term recovery from addiction. They serve as connectors and navigators in recovery support systems and offer resources such as housing, employment and other professional and non-professional services.[23] According to SAMHSA, a Recovery Coach is generally a person in long-term recovery, or a family member or significant other, who promotes recovery by serving as a person's individual guide and mentor. This coach empowers the individual in their personal journey towards recovery, offering hope while providing advocacy, guidance, motivation and knowledge. SAMHSA's Recovery Community Services Program, in which peers serve as Peer Recovery Coaches, demonstrated positive six month follow up outcomes in abstinence, legal problems, employment, housing and mental health symptoms: 75% abstinent; 94.9% no arrests; 51% employed; 51% housed; and fewer than 25% mental health symptoms. An independent evaluation of peer support services in Tennessee and Wisconsin found hospitalization days decreased by 73% and 44% respectively following peer services engagement.[24] Improved outcomes are particularly notable when peer support services are provided to people with chronic conditions that require long-term self-management including diabetes, cardiac disease and cancer.

The Bureau of Substance Abuse Services (BSAS) has added to its training schedule a four day **Recovery Coach Academy** (RCA) training for both peer Recovery Coaches and their supervisors.[25] The Recovery Coach Academy (RCA) is an intensive multi-day training opportunity designed for those interested in becoming actively involved in serving as a Recovery Coach. In the last year, the BSAS has sponsored four RCAs, with over 160 peers and their supervisors completing the RCA. The Bureau works with MOAR and Fresh Start, a

[23] Faces and Voices of Recovery-

[24] Epps, B.,& Bellamy, C. (2010). Creating Replicable and Sustainable Peer Support Services. Yale School of Medicine. http://www.power2u.org/creating-replicable-sustainable-peer-support-services.html

[25] This training is not limited to people in recovery, family members or significant others.

program in Springfield MA, funded by the Administration for Children and Families that uses a peer recovery model for pregnant women with addictions. The peer Moms have been trained using the RCA model, adapted to specifically work with this population. MOAR and the addictions community, which has a long tradition of the integration of peer providers in service settings, rely primarily on experiential certification for peer workers.

Peers Collaborating for Integrated Supports

Peer Specialists and Recovery Coach Trainers

The Peer Training Subcommittee was initially developed as a small group of Steering Committee members and was quickly expanded to include a diverse group of trainers and training leadership within both the mental health and addiction recovery communities. This included representation from Massachusetts' Certified Peer Specialist program (developed, administered, and certified by The Transformation Center and funded by the Department of Mental Health); the Recovery Coach Academy model (developed and administered by Connecticut Community for Addiction Recovery (CCAR) and currently funded by the Bureau of Substance Abuse Services (BSAS – SAMHSA Access to Recovery grant)); and the Addiction Recovery Education Access Services (A.R.E.A.S.) group facilitation model (developed and administered by Massachusetts Organization for Addiction Recovery (MOAR)). For a full list of Training Subcommittee members, please see Appendix B.

Training Subcommittee's Vision for High Quality Peer Supports

We envision a vibrant, inclusive, high quality, equitable, respected mental health and addiction recovery support workforce, created and built upon the strength of lived experience. We believe individuals have unique characteristics and life experiences that call for a responsive, flexible, and efficient system of care intended to support individuals holistically. We believe mental health and addiction services should continue to evolve to support recovery and that the collective voice of peers and peer trainers who have lived experience should play a driving role in this evolution. Finally, we believe that none of this is possible without culturally competent practices that create equal opportunities for peers to access services and provide peer support, regardless of age, gender, race, ethnicity, disability, sexual orientation, and other personal characteristics.

According to the BRSS-Massachusetts Action Plan, the Training Subcommittee was charged with identifying and implementing methodologies for the mental health and addiction recovery communities to work collaboratively on improving the quality of peer recovery services. More specifically, this included identifying components of a peer services training curricula that would be applicable to both certified Peer Specialists and Recovery Coaches; noting commonalities and differences in training philosophy, foci, and methods; and bringing emerging consumer experts to guide the process. Overall, the intention was to bring the two training communities together to understand each other, examine needs, and develop future partnerships to aid in improving quality of peer supports statewide. Training Subcommittee outputs included their vision statement for high quality peer supports, a contact and biography document to encourage ongoing communication, the

identification of general themes pertaining to their communities' similarities and differences (ultimately influencing training practices and content), and a crosswalk of existing training commonalities and differences.

The culmination of this work was a set of training recommendations that were incorporated into this final report (for recommendations specific to the Training Subcommittee, please see Appendix B). The Subcommittee's recommendations emphasized the importance of cultural competence and universal accessibility as the foundation of all future work. Also included in the recommendations was the development of a comprehensive workforce development plan with concrete workforce projects and strategies to enhance the quality and availability of peer worker services. This includes the development of a collaborative training module on co-occurring conditions and the creation of an experience-based (rather than academic-based) peer worker career ladder. To see the crosswalk, general themes, and more detailed recommendations associated with the Peer Training Subcommittee, please see Appendix B. Given the commitment of mental health and addiction peer worker trainers who have participated in this work, the Training Subcommittee has chosen to continue to meet despite the end of grant funding. As of February 2013, the Subcommittee had two additional meetings scheduled for 2013: March 11th and April 8th. These meetings will be used to discuss their required resources and prioritization for future collaboration.

Recovery Centers and Recovery Learning Communities

RCs and RLCs peer leaders have been successful in working together despite philosophical and linguistic differences noted above, primarily because leadership and colleagues have lead and modeled civil dialogue. There are three primary reasons. First, they have engaged in an "Appreciative Inquiry", with discussion over collaboration or operations based on an **"Acknowledge [differences], Dialogue, Process, and Accept" (ADPA**) approach (see Appendix C)**.** Leaders here respect the differences in the communities, try to be self-reflective on their own prejudices, and collaborate or at the very least co-exist. Second, and a corollary to the above, has been the presence of effective leaders, who devote themeselves to a mission and related projects, are good listeners, and are clear in their repsectful communications. Third, and also a corollary to the appreciative inquiry approach, peers must chose to work from commonalities. A concept shared by both communities is recovery, characterised by both group as an inner capacity to attain wellness and community integration, that people can be effective parents, spouses, workers, etc, with the right kind of assistance. In addition, both group see peer supports as a vital component of recovery. In Western Masachusetts, the strongest commonality is the shared recognition of "trauma" as a major contributing factor a person's poor mental state[26], with trauma-informed care considered a key componenet necessary to support recovery[27] (See Appendix C).

Barriers Faced by People with Co-occurring Disorders

People who have both mental health and addiction disorders, in effect "co-occurring disorders", face very poor outcomes, including high rates of relapse, homelessness, and criminal activity. Because mental illness

[26]Felitti VJ, Anda RF, Nordenberg D., et al (1998). The relationship of adult health status to childhood abuse and household dysfunction (ACE study). American Journal of Preventive Medicine. 14:245-258.
[27]See http://www.samhsa.gov/nctic/trauma.asp

and addictions have historically been seen as very different conditions, practitioners have generally attached themselves to only of the fields, and have been unprepared, and often unwilling, to treat persons from the disorder they are unfamiliar with. As a result, people with co-occurring disorders have often been excluded from services, such as housing services that require no prescription medication use. In addition, mental health and recovery support systems have developed under separate state and provider agencies or divisions, each with its own funding mechanisms, job classifications, criteria for credentials, and treatment systems. Thus, people with co-occurring needs are often challenged with navigating these separate care systems.

As is true across the country, the mental health and addictions peer communities have been, for the most part, working in parallel while supporting individuals to navigate the two separate systems of care. Mirroring the fragmentation that exists, peers have been challenged sharing best practices in training and peer support strategies across the two communities. They have also struggled with allocating the resources required to successfully support the vast numbers of individuals experiencing co-occurring challenges. This project has shed light not only on the need to build peer systems sensitive to the unique traits and histories of peer movement. Both communities (through this project) have validated existing research and the need for persons with co-occurring disorders to be treated simultaneously and supported by mental health and addictions providers and peer recovery services.

BRSS-Mass Health Systems and Policy Recommendations

The recommendations provided below are concrete strategies for the Commonwealth to initiate and maintain recovery oriented behavioral services within the developing and new model of integrated health care delivery. Their intent is to promote the use of peer recovery services and specialists as agents of change to recovery-oriented services, with special attention to people with co-occurring disorders. These recommendations are built on the unique expertise of the Policy Academy (representing both mental health and addictions communities), research, technical assistance, fact-finding efforts, and analyses conducted as a part of this project. The dynamic collaboration of behavioral health peer, state agencies and provider agencies through BRSS-MASS has resulted in a set of five recommendations, with subsets of recommendations based on the following categories: 1) Person- and Community-Level Integration, 2) Systems-level Integration, 3) Provider-level integration.

1. Recognize Peer Specialists/Workers and Recovery Coaches as essential, foundational elements of existing and developing models of health care delivery

Person/Community Level

a. Continue to host and support leadership meetings inclusive of representatives from the peer communities, the Department of Public Health, the Department of Mental Health, the Office of Medicaid, and primary health providers, behavioral health providers, and academic partners. The BRSS-MASS Steering Committee would support and monitor the integration of mental health and addictions recovery approaches, including peer workers, into new models of care (e.g., Health Homes).

b. Examine the potential for adding partners to the steering committee, including representatives of new models of care, primary care providers, and community health workers.

Provider Level

a. Peer workers need to be meaningful members of those treatment teams and care coordination organizations that are responsible for the care of people with mental health, addictions, or co-occurring disorders.
b. Trainings on mental health and addiction recovery practices, including how to include peer recovery workers, should be to entire treatment teams, not just specific professions.

Systems Level

a. Host a series of workshops (in collaboration with MassHealth and BRSS-MASS Steering Committee) on the roles and benefits of peer recovery workers within the new integrated models of care. Key workshop participants should include Integrated Care organizations (ICOs), state agencies, behavioral health providers, community health centers, medical and health home providers, systems leaders, and any other stakeholder of EOHH's duals initiative to integrate Medicaid and Medicare funding. Special attention should be given to the importance of establishing recovery-oriented systems of care and eliminating health care disparities.
b. The peer recovery worker role should be financed at all levels of program design and implementation, through both global payments and fee for service models[28].
c. Paid peer roles should be sustainable, and have competitive payment and benefit strategies comparable to non-peer paid roles.
d. A menu of community support workers for "chronic conditions," including certified Peer Specialists and Recovery Coaches, should be financed and available to consumers, with sufficient information for the consumer to make a meaningful choice from this menu. Community and peer workers should be representative of the diversity of individuals being served.
e. Identify and implement ways in which peer recovery workers can be utilized to support individuals who can be difficult to reach (e.g., those on waiting lists for services, homeless, and court-involved).
f. Identify and implement ways in which peer recovery workers can be utilized to support individuals from a diverse demographic, including individuals who are of all cultures; of all ages (e.g., adolescents, transition age youth, and elders); speak a different language are deaf or hard of hearing; have physical challenges; and have intellectual or developmental challenges.

[28] Per the BRASS-MASS response to the MassHealth Comprehensive Primary Care Payment Reform RFI: "The Mass Health Community Integration Domain includes Self Help and Community Resource Connections and Specialty Mental Health and Substance Use Referral Connections as essential, required elements of integrated care delivery. Although Peer Support Services are viewed as enhancing integration, they are not required of participants in the Comprehensive Primary Care Payment Reform strategy. The BRSS-TACS Steering Committee urges Mass Health to require Peer Specialist and Recovery Coaches as an essential, foundational element of the Community Integration Doman."
CMS SMDL No. 07-011 letter (2007).

2. Through the new models of integrated care, develop a comprehensive, recovery-focused system of care for people with co-occurring mental health and addiction disorders

Person/Community Level

a. Educate stakeholders statewide on the prevalence of co-occurring disorders and the barriers to providing effective and holistic recovery-focused treatment practices.
b. Determine efficient methods for bringing Recovery Centers and Recovery Learning Communities together routinely (e.g., during monthly meetings already occurring) in order to work collaboratively at the state and regional level, and fund opportunities for their partnership.

Provider Level

a. Provide specific guidance on building an effective co-occurring service system reflective of recovery principles. Create and/or disseminate the tools needed by Primary Care Clinicians to provide high-quality, patient-centered services.
b. Develop statewide recovery-focused practices within new and existing systems of care to address the needs of individuals with co-occurring disorders.
c. Develop evidence-based co-occurring provider training reflective of recovery best-practices.

Systems Level

a. Identify strong practices[29] within Massachusetts (e.g., Massachusetts Behavioral Health Partnership) for replication and scalability.
b. Share evidence-based practices and work with partners (e.g., UMASS Medical School[30] and SAMSHA) for technical assistance and to gain access to grant funding.
c. Develop a roadmap for implementation and performance assessment, while assessing the cost-effectiveness of implementation mechanisms for populations with co-occurring disorders.

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[29] MISSION DIRECT is a unique program in Massachusetts developed by Smelson and colleagues in which case managers and peers work together to deliver specialized services for individuals with a co-occurring disorder. It has been developed and studied over the past 15 years in both randomized and non-randomized trials and includes both a veteran and non-veteran manual to help with fidelity, and already funded by DMH (http://www.mass.gov/veterans/benefits-and-services/mission-direct-vet.html)

[30] One well-known integrated approach is Dual Recovery Treatment (DRT), developed by Douglas Ziedonis (Chair of Dept. of Psychiatry at UMass Medical School) and colleagues. DRT focuses on three broad areas: 1) screening, assessment, and planning; 2) psychosocial and pharmacological treatment; and 3) systems of service provision. A core element of DRT is client education, supplemented by skills to build motivation. Ziedonis, D. M., & Stern, R. (2001). Dual recovery therapy for schizophrenia and substance abuse. Psychiatric Annals, 31, 255–264.,

3. Sustain and improve the quality of peer recovery supports within the Commonwealth, including peer-run recovery centers and communities

Person/Community Level

a. Address the need for universal access, inclusion, and cultural competence throughout all peer support development and training work. Every product and/or project, including recommendations listed in this report, should address universal accessibility and cultural competence.
b. Invite and explore continued partnerships among mental health and addictions peer trainers (e.g., through the continuation of the trainer subcommittee and the funding of a Peer Workforce Development Forum). Solidify the commitment of recovery community members to work together to improve the quality and integration of peer training. Consider how to meet the unique needs of individuals with a co-occurring mental health and substance abuse problem and whether support should be accessed through mental health, addictions, or a new specialty peer support program.
c. Develop a workforce development plan with training partners that improves the overall quality and coordination of peer recovery workforce training within the Commonwealth. Improve training content and processes, and create an experience-based career ladders.
d. Educate stakeholders statewide on the components of work environments that support and maximize the value of a culturally and professionally diverse workforce.

Provider Level

a. Every Peer Specialist should interact regularly with a Certified Peer Specialist or Recovery Coach supervisor and peer colleagues, and they should have access to group Certified Peer Specialist/Recovery Coach "supervision" (e.g., through an RLC, MOAR or The Transformation Center).

Systems Level

a. Address the need for universal access, inclusion, and cultural competence by financing a training team and recruitment strategies that ensure these outcomes. Every product and/or project needs to address universal accessibility/cultural competence (including the recommendations listed in this report.)
b. Clarify and promote fidelity to Certified Peer Specialist and Recovery Coach standards, including supervision standards, and catalogue best practices through a web-based portal.
c. Provide opportunities for Recovery Centers and Recover Learning Communities to collaborate (See Appendix C).

4. Support the establishment of policies for the successful integration of peer workers and Recovery Coaches in all health care delivery models.

Person/Community Level

a. Support BRSS-MASS Steering Committee to develop a best practices policy manual to successfully support the inclusion of, and access to, peer recovery supports within existing models of care and newly developing integrated models. Topics may include:
    1. Culture change among those providers which have yet to recognize the benefits of peer support, including policies that are supportive of peer support practices;
    2. Understanding and accessing accurate information and technical assistance on peer roles, including sample job descriptions, supervisor orientation, and practice and supervision standards. Identifying the similarities and distinctions between the Peer Specialist/worker and "Recovery Coach" roles, and preventing conflation of them.
    3. The importance of consumer choice in peer workers and of peer workers being representative of the diversity of individuals being served. Consumers should have a choice of whether or not to work with a peer worker.
    4. Creating access to peer services, regardless of diagnosis, provider, or services needed; and
    5. Hiring processes, the accrual and use of benefits, and reasonable accommodations in relation to the work goals of the organization. Support Human Resources staff to gain knowledge about a wide range of insurance and other resources related to employment success.

Provider and Systems Level

a. Share information on peer services (the role and benefits) with various stakeholders to sustain high quality peer services within new models of service design. At a minimum, information should be formally shared and technical assistance provided to Primary Care Providers, Health Home Providers, Accountable Care Organizations, and Behavioral Health Providers.
b. Generate opportunities for collaborations between Community Health Workers and peer recovery workers, to share information, identify common practices, and explore partnership.

5. Develop a peer workforce that is culturally competent and representative of the communities being served.

a. Work with people from diverse communities to test value-bases and philosophical assumptions as we move forward in our peer development and training efforts.
b. Educate ourselves and other stakeholders (e.g., trainers, decision makers, and others who have a stake in peer supports) about disparities within our existing systems and the philosophical underpinnings and values that create disparities.

c. Create direct linkages between disparity elimination efforts and system-wide implementation of Peer Specialists, peer workers and Recovery Coaches.
d. Actively seek and recruit planning partners and meaningful participation of groups/communities that have been historically underrepresented with respect to accessing services and supports that address behavioral health and foster recovery.

Conclusion

The past decade has brought forth a clear policy perspective that the mental health and addictions fields should be at the very least working collaboratively, if not integrated. New health reform efforts require care integration, with a holistic focus the person rather than just a single diagnosis or program. What these systems have in common is a burgeoning interest in supporting a long-term recovery process, as opposed to an acute-care, deficit based approach. In addition, people with either of the disorders face some very similar challenges, and could benefit from the exact supports (e.g., court-involvement, housing, income support). Peer Recovery Supports are essential elements of the modern health care system. In a 2010 Description of a Modern Addiction and Mental Health Service System, SAMHSA recommends a set of service elements that includes community integration and social inclusion, health promotion, and mutual support. In addition, a "good and modern" system has structures and competencies including a workforce with trained peer supports, and a set of principles including recovery and other support services to promote social integration, optimal health and productivity. We hope that our BRSS-MASS effort s have contributed to those goals. This collaboration has continued us on our path to a cohesive/collaborative recovery voice among peers of both addiction recovery community and the mental health consumer/recovery community, an area in which Massachusetts is a clear leader. Continued collaboration among BRSS-Mass members and other key stakeholders is essential for continued success.