



# SAMHSA'S EXPERT PANEL ON STRATEGIES FOR PEER-RUN/RECOVERY COMMUNITY ORGANIZATIONS TO BUILD COLLABORATION & RELATIONSHIPS WITH LOCAL, COUNTY & STATE-LEVEL GOVERNMENTS

This paper provides background and context for the Substance Abuse and Mental Health Services Administration's (SAMHSA's) BRSS TACS Expert Panel Members to discuss strategies for peer-run organizations and recovery community organizations (POs/RCOs) to build collaborations and relationships with local, county, and state-level governments. The paper delivers a focused range of documented information that will support panel discussions, allowing panel members to probe more deeply into many of the topics presented here.



BRINGING RECOVERY SUPPORTS TO SCALE  
*Technical Assistance Center Strategy (BRSS TACS) Expert Panel*

# SAMHSA'S EXPERT PANEL ON STRATEGIES FOR PEER-RUN/RECOVERY COMMUNITY ORGANIZATIONS TO BUILD COLLABORATION & RELATIONSHIPS WITH LOCAL, COUNTY & STATE-LEVEL GOVERNMENTS

September 17 – 18, 2013

## INTRODUCTION

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The purpose of this paper is to provide background and context for the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Expert Panel Members to discuss strategies for peer-run organizations and recovery community organizations (POs/RCOs) to build collaborations and relationships with local, county, and state-level governments. The paper delivers a focused range of documented information that will support panel discussions, allowing panel members to probe more deeply into many of the topics presented here.

## COLLABORATIONS: PROVIDING SUPPORT & PROMOTING RECOVERY

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In its landmark report, *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*, the Institute of Medicine (IOM) emphasized the importance of peer support and peer-delivered services (IOM, 2006). The Annapolis Coalition on the Behavioral Healthcare Workforce (2007) identified peer-delivered services as one of its areas of emphasis to transform the behavioral health workforce and prepare for anticipated workforce shortages in the face of healthcare modernization.

As with the IOM and Annapolis Coalition, SAMHSA has people in recovery at the core of its focus to reduce the impact of substance use disorders and mental illness on America's communities. SAMHSA's goal is a high-quality, self-directed, satisfying life integrated in a community for all Americans. This life includes health, home, purpose, and community. SAMHSA works to accomplish this goal through its partnerships, policies, and programs that build resilience and facilitate recovery for people with or at risk for mental and/or substance use disorders (SAMHSA, 2011). SAMHSA leverages all of its resources—programs, policies, and grants—toward this outcome.

Partnerships between POs/RCOs and local, county, and state-level governments are critical to ensuring a broad range of services and supports that go beyond traditional treatment. Behavioral health services and supports strive to be responsive to the needs and goals of people in recovery and their families and POs/RCOs provide essential supports to people in recovery and their families.

In municipalities, counties, and states across the country, program administrators and agency officials are making policy and programming decisions about funding, regulations, and authorization of peer services and peer workers. Their decisions will have long-lasting implications on the quality, cost, type, and frequency of services and supports that people will receive. To ensure that these decisions are fully peer-informed and recovery-oriented, it is essential that advocates and RCOs are informed and vocal participants in the decision-making process (Faces and Voices of Recovery, 2013).

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In the context of this paper, we define *peer-run organizations* (POs) as organizations that are administratively controlled and operated by people in recovery from mental health conditions and their family members. *Recovery community organizations* (RCOs) are administratively controlled and operated by people in recovery from substance use disorders and/or their family members and allies. Both POs and RCOs emphasize peer support and community outreach in their missions.

As important organizations within the behavioral health field, POs/RCOs work to ensure that services and supports, including peer recovery support services, are accessible and available. People in recovery and their family members have a central role in the decision-making process in systems and programs meant to treat mental and/or substance use disorders, build resilience, and facilitate recovery.

To support PO/RCO collaborations with local, county, and state-level government, many POs/RCOs are interested in learning and executing effective strategies that build effective partnerships. Similarly, states are asking how they can support POs/RCOs to ensure that they stay in business and play a vital role in the system of care. This expert panel will identify strategies for developing effective collaborations as well as successful partnerships that serve as examples. The panel will seek to answer questions, such as (Ostrow, 2010):

- What is the stated purpose of the PO/RCO? In order to accomplish this stated purpose, what organizational relationships are imperative for success?
- How are relationships established with the state's mental health authority, the single state authority for substance abuse prevention and treatment services, or other state officials and providers who have control over allocating resources?
- How can the PO/RCO preserve its core values and vision while securing funding?
- Are peers ready to take action when there is an opportunity to testify publicly at the local, county, or state level? What is the message to be delivered?

### Principles of Collaboration

The critical need for POs/RCOs to work effectively with other behavioral and health care disciplines has been discussed in the recovery literature. The question remains, however, how to conduct collaboration more effectively. Focusing specifically on building local, county, and state collaborations is imperative in the current changing environment under the Affordable Care Act, a law that significantly affects possible roles and funding opportunities for POs/RCOs. It is important to define *collaboration* and to understand that certain guiding principles of relationship-building are critical if POs/RCOs are to flourish within this changing environment.

### Collaboration Defined

The following description of *collaboration* is based on the work of both Follett and Gray (Gardner, 2005):

Collaboration is both a process and an outcome in which shared interests or key stakeholders address conflicts that cannot be addressed by any single individual. A key stakeholder is any party directly influenced by the actions others take to solve a complex problem (stakeholders can be PO/RCOs, insurance carriers, health providers, state human service agencies, consumers, families, schools, communities etc.). The collaborative process involves a synthesis of different

perspectives to better understand complex problems. A collaborative outcome is the development of integrative solutions that go beyond an individual vision to a productive resolution that could not be accomplished by any single person or organization.

### Principles in Establishing Collaborative Relationships

Increasing collaboration between POs/RCOs and local, county, and state governments may rely on the following principles related to establishing collaborative relationships (National Association of County and City Health Officials, 2005):

**Educating.** Behavioral health, public health, and government policymakers and practitioners need to work alongside PO/RCO representatives in order to further understand and continue to increase awareness of POs/RCOs contributions and the need for collaboration at all levels, among local, county, and state governments.

**Planning.** There is a need for POs/RCOs to participate in developing collaborative plans at the local, county, and state levels that address the behavioral health needs of individuals, families, and communities as identified in local community, county, and state needs assessments. Strategic activities need to respond to issues identified in community needs assessments, and work towards mutually agreed upon priorities.

**Partnering.** POs/RCOs and local, county, and state-level governments need to create and foster partnerships that promote behavioral health and prevent adverse conditions. Partnerships must occur across all activities and situations, such as education, emergency/disaster response, and for all target populations, including prison and jail populations.

**Communicating.** Communication among POs/RCOs and behavioral health professions, and among community groups, policymakers, and the public is fundamental. Communication is essential for effective collaboration, planning, and partnership. Forums (e.g., focus groups, conferences) encourage dialogue and improve communication among POs/RCOs and behavioral health service providers. These forums have several functions, including providing opportunities for information sharing, learning, and planning. Participation in shaping—or at least being aware of—the structure of such forums can aid collaboration in subtle ways. Sharing information about funding streams, assessed needs, and best practices can facilitate increased collaboration and support.

**Resolving conflict.** Conflict resolution is the cornerstone of collaborative success. In the collaborative paradigm, conflict is viewed as natural and as an opportunity to deepen understanding and agreement. Conflict can both hinder and facilitate collaboration. When using conflict to facilitate collaboration, it is helpful to distinguish between emotional conflict and task conflict. *Emotional conflict* centers on relationships between individuals and can evolve from a task conflict. *Task conflict* centers on disagreements about how to achieve a common objective. Task conflict is often easier to address than emotional conflict. A cognitive debate over how to approach a task can facilitate development of a shared understanding and create the necessary perspective for problem solving (Jehn, 1995). Early efforts at planning, partnership, workforce

development, communication, and conflict resolution among POs/RCOs and local, county, and state governments will further increase collaborations that help people manage their recovery from mental and substance use disorders. As POs/RCOs build collaborations, it may be helpful to identify existing programs that provide examples of collaborative efforts among local, county, and state governments.

### LOCAL & COUNTY GOVERNMENT COLLABORATIONS

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Collaborative support programs directed, managed, and staffed through the collaborative efforts of people in recovery from alcohol and/or drug addiction, mental health consumers, survivors, and non-consumers can provide individualized, flexible community-based services that promote responsibility, recovery, and wellness. The following are examples of local and county collaborations.

**Peer-staffed discharge specialists.** Hospitals and other traditional mental health services have employed peers as discharge specialists (instead of the traditional care advocate/social worker). The primary responsibility of a peer discharge specialist is to connect with a person who has just returned home from the hospital and work to make the transition from hospital to home successful. The peer discharge specialist is responsible for working with people on their aftercare appointments and for the social/environmental supports that promote recovery (e.g., support groups, drop-in centers, WRAP).

**Peer specialists/peer recovery coaching.** Working in POs/RCOs or within other service environments, people in recovery are trained to serve as a personal guide and mentor for people seeking or already in recovery, regardless of the pathway to recovery. Peers provide

- emotional support;
- assisting with setting recovery goals and developing recovery plans;
- restructuring life and daily schedule to accommodate recovery;
- developing new friendship networks;
- forming and improving life skills; and
- gaining access to services and resources.

Peer specialists and peer recovery coaches can be trained and employed to assist peers before, during, after, and sometimes instead of, formal treatment.

**Warm line: Peer & family support by phone.** A warm line is staffed by trained peers who have experienced mental health recovery in their own lives or in the lives of their family member. Warm lines provide emotional support, recovery education, and self-advocacy support. The warm line is not a crisis hotline, but is based on the concept that sometimes what is needed most in difficult times is someone to talk to, who will listen and understand.

**Telephone-based peer support.** This peer-to-peer recovery support program is similar to other peer support and peer recovery coaching programs; however, it is limited to phone support. Volunteers reach out over the phone to individuals seeking recovery in order to connect them to needed resources for achieving and maintaining recovery. Telephone-based peer support may be used as an engagement



strategy for individuals who are on waiting lists for formal treatment services. It is used in rural areas where distance presents a barrier to face-to-face meetings.

**Recovery support services.** Peer-delivered recovery support services are delivered through organizations and often through the specialized roles of credentialed, paid recovery support specialists. Recovery support services may include

- *Leading recovery classes at a mental health center, addiction treatment center, or peer-run/recovery community organization:* Recovery support specialists may teach classes, such as Wellness Recovery Action Plan (WRAP<sup>®</sup>), relapse prevention, and life skills, or they may facilitate recovery support groups.
- *Providing individual and group recovery support:* Sometimes individual or group support is provided at a mental health center or substance abuse treatment center within specific programs, or provided in the community as part of a center's Community Support, Assertive Community Treatment, program.
- *Mentoring persons in a recovery drop-in, center:* Drop-in centers are informal places individuals can come to give and find peer support with others. Classes and peer support groups may be offered by Recovery Support Specialists, but often there are also opportunities for persons served to develop their own shared interest groups and activities.

**Permanent supportive housing (PSH).** Collaboration with a permanent supportive housing (PSH) model or housing placement services works to provide safe, decent, affordable, and permanent supportive housing to low-income persons with special needs.

**Transitional recovery housing & sober-living environments** offer various degrees of structure for individuals who desire safe, substance-free housing. Many are peer-run and may or may not be part of a host agency. These environments may or may not provide additional recovery support services in conjunction with housing.

**Interpreter services** (also known as deaf, hard of hearing, late-deafened, or deaf-blind services). Collaboration with community mental health centers and addiction treatment centers in the provision of reasonable accommodations for individuals who need sign language interpreter services.

**Integrated care, medical homes, and health homes** facilitate the incorporation of peer/family-run organizations and recovery community organizations as supplementary service providers in person-centered health homes. Person-centered health homes hire peers directly or may partner with peer/family-run organizations and recovery community organizations.

**Family navigator programs** help families with children in the mental health system or the adolescent treatment system. A designated navigator provides support as the family navigates the many systems necessary to get help for their child. To become a navigator, an individual typically must have a child in the system. In this way, navigators can often be more empathetic.

**Peer navigators.** A PO/RCO can train peer health care navigators or train providers in how to use peer navigators. The PO/RCO may recommend that major carriers employ a cadre of peer navigators in order to link clients to primary care, identify barriers to care, develop plans to reduce barriers, determine eligibility for health insurance, provide referrals to community resources, and remind participants of pending appointments. These peer navigators may be employed by a PO/RCO.

**Parent empowerment services** support parents who have a child with emotional and/or behavioral concerns. The focus is on giving parents information and strategies that they may need to advocate for and support their children. Some states offer the Certified Family Partnership Professional (CFPP) credential. These professionals are individuals who are trained to incorporate their unique life experiences that they have gained through parenting a child who had emotional and/or behavioral challenges. These challenges required parents to access resources, services, and supports from multiple child-serving systems as they progressed toward achieving family goals.

**Self-help centers** are designed to empower people living with mental and substance use disorders to realize a lifestyle centered on wellness that is a balanced state of social, spiritual, mental, emotional, and physical health. Services can include self-help groups, advocacy socialization, opportunities for empowerment and leadership, stepping-stones to personal growth, and accessing resources.

**Recovery community centers** provide a hub for peer recovery support services, community supports, and a public space for individuals and families to convene in a supportive environment that promotes recovery from mental illness and addiction.

**Supported employment/recovery-oriented employment services** assist people succeed in long-term and sustainable employment. Services can include assistance in seeking and obtaining employment, reporting income, creating resumes, and career counseling. Services may include individualized follow-along support, such as on-the-job coaching, coping and problem-solving techniques, ongoing benefits counseling, and assistance with choosing to leave a job.

**Financial services** offer financial products and services aimed at promoting financial literacy, money management, development of long-term savings skills and habits, and asset acquisition. Financial services may aid in services related to Individual Recovery Accounts, which allow individuals to directly purchase their needed services.

**Peer-run respite services.** A relatively new form of residential crisis services, trained peers operate peer-run respite services for people experiencing mental health crisis. Peers operate the respite services at all levels, and at least 51 percent of the board of directors self-identifies as people in recovery. A hybrid peer-run respite service is often attached to a traditional provider organization. Or peers may comprise less than half of the board of directors, however, the director and staff of the respite service identify as peers. An alternative to psychiatric hospitalization, peer-run respite services provide a safe, mutually supportive, nonjudgmental, educational, and self-empowering environment for those experiencing an emotional crisis (National Empowerment Center, 2013).

**Public inebriate programs.** In collaboration with law enforcement and local addiction treatment programs, trained peer recovery workers provide support and supervision for day and overnight programs, ensuring the safety of the program participant while providing early engagement with community-based services, such as peer mentoring, recovery coaching, mutual support groups, and recovery community centers.

**Peer-run health training.** Peers offer a wide range of wellness programs. One county program hopes to decrease the number of people who smoke by 20 percent among people using mental health services. This project arose when the peer-run organization contacted the County Public Health and Tobacco Coalition and proposed the program. Another organization started a SMART Recovery (Self-Management and Recovery Training) to run smoking cessation support groups in English and Spanish. The SMART Recovery 4-Point Program helps people recover from addiction and addictive behaviors, including drug abuse, drug addiction, substance abuse, alcohol abuse, gambling addiction, cocaine addiction, prescription drug abuse, and problem addiction to other substances and activities. Many peer organizations use WHAM (Whole Health Action Management) to help people in recovery improve their overall health and wellness.

## STATE GOVERNMENT COLLABORATIONS

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**Peer education & support statewide call-ins.** Several states host a toll-free telephone call-in for persons receiving services. The call-in may consist of a half-hour presentation on a topic important to people living with mental and substance use disorders and their families. The presentation may be followed by time for questions and answers.

**State navigator programs.** Through the ACA, insurance reform and Medicaid expansion, there are key opportunities for delivering peer support services and creating PO/RCO partnerships with more than 100 organizations around the country. Federal health officials awarded \$67 million in grants to organizations to help uninsured consumers sign up for health coverage in new insurance marketplaces this fall. The exact number of navigators to be hired will be made by the individual organizations receiving these grants. Grantees, including universities, health departments, and health systems (e.g., Ascension Health, the country's largest Catholic and nonprofit health system), Planned Parenthood affiliates in Iowa, Montana, and New Hampshire, received grants totaling \$655,000 (Sun, 2013). Navigator grants are made from the health insurance exchanges' operational funds, not the federal funds received by the state to establish the exchange.

**Regional & statewide recovery conferences.** Peers participate in the planning of conferences designed to provide hope, education, and empowerment to persons living with mental and substance use disorders.

**Mental Health First Aid Training.** The Mental Health First Aid course mimics regular first aid training and teaches the general public how to deal with a mental health emergency until an appropriate professional can provide treatment, if needed. Peers and non-peers nationwide are learning to lead this program and to provide data supporting the training's efficacy. Members of law enforcement, among others, benefit from this training.



**State advisory/planning council member.** People in recovery from mental illness and/or addiction can work with the State Mental Health Authority (SMHA) and/or the Single State Authority (SSA) to influence planning, evaluation, resource allocation, and policy development. Relationships with just one state official, for example, can lead to more relationships with decision makers, thus creating a snowball effect.

**Members of prevention & mental health promotion advisory groups.** People in recovery and their family members work to facilitate the involvement of public health in promoting wellness and recovery. They work to increase awareness of relevant concepts, such as adverse child experiences (ACEs) and trauma-informed care, across mental health, substance use, education, and broader child-serving systems.

**Criminal justice collaboration** focuses on improving behavioral health services in the criminal justice system and collaborates to address behavioral health reentry issues. According to Bureau of Justice Statistics, 56 percent of state prisoners have a mental illness and 45 percent of federal prisoners have a recent history of mental health problems. Fifty-three percent of state prisoners and 45 percent of federal prisoners met the DSM-IV criteria for drug dependence or abuse (Mumola & Karberg, 2007). POs/RCOs can affect the practice of incarcerating people with mental illness or substance use disorders rather than providing community-based, recovery-oriented services.

**Education collaboration** is a process for training consumers/people in recovery to provide recovery education to their peers. Recovery education may need to be designed by and for consumers/people in recovery to educate peers, family members, service providers, and/or administrators.

## CONCLUSION

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The consumer movement in the mental health field, which began in the 1960s, promoted the ideas that recovery is possible and that people should play a key role in their own recovery and in the services and systems that they use. Similarly, people in recovery from addiction, their families, friends, and allies have become part of the organized addiction recovery movement, which currently includes hundreds of recovery community organizations that provide advocacy, education, and peer support services, and celebrate recovery within their local communities.

POs/RCOs promote recovery, empowerment, and community integration within the mental health and addiction fields. Peer specialists and peer recovery coaches provide vital services in a number of settings, such as clinics, recovery community centers, health homes, hospitals, and consumer-operated agencies.

POs/RCOs are increasingly positioning themselves to help local communities, counties, and states provide effective services possible for people with mental illnesses and substance abuse conditions. Through collaboration, POs/RCOs will continue to evolve dynamically within the behavioral health workforce.

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