

*Rockland Recovery: A Peer Support Learning Community
Program Description*

TARGET POPULATION AND NEED

Rockland Recovery will focus on recovery peer support for the almost 2000 adults each year who move from institutional settings (hospitals, jails, or prisons) into the Rockland area community and who have addictions issues or coexisting disorders. This transition from institution to community is a crucial and delicate moment in the recovery process. In order to foster and enrich the process of change that is the recovery process, Rockland Recovery will provide a sense of hope, support, education, and the empowerment of a learning community.

Many, if not most, of these 2000 Rockland area residents have co-existing disorders. There is a consensus among clinicians and researchers that almost all addicted people have serious trauma issues and often should be treated for co-existing disorders.¹ Most of the detoxification patients at Penobscot Bay Medical Center are placed in the PARC Unit for co-existing disorders. Moreover, a relatively high proportion of people with other mental illnesses develop substance abuse problems.²

The need for transition support is clear—without it relapse is considerably more likely and relapse is expensive both for the individual and the community. This generally takes the form of renewed episodes of acting out, often in ways that are destructive to the person and to others. It is one of the major reasons offenders “come back”—repeat the same or other offenses³—and non-offenders “come back” to crisis units or, worse, end up incarcerated. In any event, relapse has huge costs beyond the individual—beyond potential harm to direct and indirect victims, there are the huge costs of mental health and correctional programs. There is an urgent need to reduce these costs by reducing relapse.

There is a strong and vital 12-Step community in the Rockland area, primarily Alcoholics Anonymous. Unfortunately, only a bare handful of Rockland Recovery’s target population find their way into this community. There seem to be various reasons for this including a lack of knowledge and comfort, especially among ex-prisoners. Many people with multiple addictions and addictions other than alcoholism have a very hard time finding a self-help community in the Rockland area. In addition, stigma, lack of mental health education, and hostility to medications among many members, means the necessary environment of empathy

¹ See, for example, K. Evans and J. M. Sullivan, *Treating Addicted Survivors of Trauma* (Guilford Press, 1995) and Center for Substance Abuse Treatment, *Substance Abuse Treatment for Persons with Child Abuse and Neglect Issues* (SAMHSA, 2000).

² For example, see New York State Office of Mental Illness, “Integrated Treatment for Co-Occurring Substance Abuse and Mental Health Disorders.”

³ Jeremy Travis, “But They All Come Back: Rethinking Prisoner Reentry,” National Institute of Justice, 2000

and acceptance may not be present for mental health consumers—those who have a co-existing mental health disorder.⁴

A non-random sample of dozens of people in the Rockland area who have gone through the transition from institutional care to the community confirms that there is a lack of peer support available in the area and few places to share ideas, fears, strategies, hopes and frustrations, or to simply gain support from those who have or have had the same experiences. Most often mentioned in these conversations are the dimensions of company, hope, education, tools/skills of recovery, and self-esteem reflected in autonomy and empowerment issues such as employment, housing, education, and helping others.

Change is difficult. This is nowhere more daunting than the process of transition from an intensive institutional environment back into a community. The transition itself is change—moving is always stressful. But recovering people are faced with the additional task of implementing the changes in their own lives that are essential to recovery. They are moving from a narrow and controlled environment, often replete with disempowerment and helplessness, into an almost dazzling and immense social environment. A multitude of persons, places and things await to trigger thoughts and feelings that threaten to overwhelm them, along with their own abiding and often reinforced sense of shame and stigma. This is the fragile beginning of a new life and it is not surprising that this new beginning often collapses or is crushed. And, as Bullock, *et al*, put it, “Critical ingredients for recovery such as hope, empowerment, self-determination, and a new valued sense of self, are clearly in double- or triple-jeopardy for the mental health consumer who is also a criminal offender.”⁵

In some ways, this transition is easier for those who move back into their old lives—who return to the same housing and family and friends. The physical transition is less daunting yet those same elements prompt the same habits of thought and feeling and action—prompt the same maladaptive coping habits that they are trying to change. Moreover, the well-intentioned concern and support of family and friends can promote dependency and helplessness and/or increase a sense of shame and stigma—to be an invalid is to be invalid. Thus, recovery peer support for these people is a crucial source of hope and empowerment.

For those who begin new lives, the physical transition is more daunting with immediate need for housing, transportation, and employment. Being overwhelmed by these tasks coupled with rejection and being shunned may lead to a sense of helplessness, hopelessness, shame and stigma. Lack of a community of support may lead to loneliness and isolation, discouragement and even despair. These thoughts and feelings, in turn, can prompt the same maladaptive coping habits that they are trying to change. However, *accomplishing* the tasks of physical transition can be an extremely valuable source of self-esteem, empowerment and hope. Thus, peer support for these people is a crucial source of encouragement, assistance and support in

⁴ A substantial proportion of addicts, including alcoholics, have co-existing disorders and this proportion is even higher among those in jails and prisons. Double Trouble in Recovery, a New York City self-help group for dually diagnosed people, notes that the issues mentioned here are a fairly common.

⁵ Wesley Bullock, PhD., Gayle H. Wuttke, Melissa Klein, and Heidi Bechtoldt, “Effectiveness of a Forensic Diversion Program in Promoting Recovery.” (State Mental Health Agency Services Research, Program Evaluation, and Policy Conference, Washington, DC, 2001)

accomplishing and sustaining these tasks as well as an opportunity for them to help others by passing on their own experiences.

For all of these people there is an urgent need for a sense of hope and empowerment in order to begin and sustain the process of change that is recovery. Social attitudes that recovery is impossible, that consumers are forever stuck in illness, defeats recovery. Thus, there is first and foremost a need to present a counter-image—a sense of **hope**. Recovery is based in the firm belief that recovery is possible. **Hope** is that belief that change is possible rather than being stuck in a stigmatized and dependent identity. Without hope there is no recovery. Recovery groups by their very public existence communicate a sense of hope, a sense that change is possible, and that people are not alone.

ORGANIZATIONAL STRUCTURE:

Recovery Peer Support and Development, Inc. (RPSDI), NAMI Maine, Mid-Coast Mental Health Center, Sweetser, and Amistad will collaborate to establish the Rockland Recovery Center, a peer support learning community. Rockland Recovery will be peer-run, directed and managed. NAMI Maine is the administrative and fiduciary agent for the project, responsible for meeting all grant requirements. RPSDI, primarily through its advisory board, will assist with fund raising and coordination with community organizations and agencies and provide on-going support and assistance. RPSDI will design the Center, manage the Center, and oversee day-to-day program mission, service, and quality. Sweetser's Peer Center and Amistad will train RPSDI's Board, Steering Committee, and Center staff in their program models and consult over time with Board and staff to assure fidelity, share valuable expertise, and assist with problem solving related to process and product. They will also assist in annual evaluations.

ORIENTATION OF THE PROJECT

The Rockland Recovery Center builds on the research about what works in peer support and recovery, utilizes models that have been successful in other states and in Maine, and relies on consultation with experienced peer support leaders and their organizations. Unlike others, the Rockland Recovery Center will integrate models from three systems that have not always worked well together: mental health, substance abuse, and corrections. This approach responds to current circumstances—deinstitutionalization has resulted in transinstitutionalization. Increasingly, people bounce between mental health services, substance abuse services, and criminal justice settings. The State of Maine has been involved in several year-long planning efforts to increase the use of integrated treatments. The federal government has recently published information about evidence-based practices they wish to see replicated. Two of these are peer directed recovery and integrated treatment. The Center will be implementing both.

The organizing understanding of this project draws on three distinct yet overlapping literatures and experiences. First, there is rich and extensive recovery and relapse prevention tradition and literature in the substance abuse field including and notably Zackon, McAuliffe and Ch'ien, *Recovery Training and Self-Help* (National Institutes of Drug Abuse, 1993). Second, there is a rich and developing recovery peer support and self-help literature in mental health, including and notably the work of Mary Ellen Copeland and Shery Mead, that draws upon and has much in common with the addictions literature. And, third, there is a rich literature

on adult learning, peer and collaborative learning, and learning communities, drawing on the tradition of Malcolm Knowles among others and developed by organizations such as New Horizons For Learning.

Marlatt and Gordon's seminal work, *Relapse Prevention* (Guilford, 1985) among many other things links relapse prevention to broad lifestyle change. Coupled with Prochaska and DiClemente's work with the stages of change (1994), the relapse prevention model, more positively conceptualized as "recovery," forms the foundation for extensive development in a variety of areas including substance abuse, anger management programs, Copeland and Mead's Wellness Recovery Action Plan (WRAP), and a series of self-help pamphlets developed by Copeland for SAMHSA.

These literatures and experiences have in common a conviction 1) that change is a process, 2) that change is possible and 3) that an essential component of successful changing is peer-to-peer collaborative support and learning.

As the leading experts on change processes put it: "Self-help groups send out a powerful message to isolated precontemplators who are embarrassed or ashamed that they have personal problems. The very existence of these groups says, 'You are not the only person in the world with this problem; we can help you to accept yourself as a person with a problem and to do the best that you can to change it.'" ⁶

The hierarchical structure of traditional mental health and education is often disempowering by promoting passivity and dependency. "The instructing and professing model ... asserts that ...the student...is essentially a passive and isolated recipient of knowledge."⁷ The Rockland area needs a collaborative learning community, such as envisioned by Knowles and others⁸, which promotes and celebrates peer-to-peer and experiential learning, especially about recovery and life skills. Collaborative learning seeks "to re-form the learning enterprise by empowering students and making them responsible for their own learning." (Lehman, 1997). The collaborative model ...asserts that learning takes place when knowledge is assimilated and becomes part of the student's repertoire for viewing, understanding, and performing. This is an active process—learning is an activity. Learning is conceived as something a learner **does**, not something that is done to the learner. The collaborative model shifts the focus from the teacher to the learner. (Lehman, 1997).

A learning community is not only the most effective method for learning but actively promotes independence, autonomy, and self-responsibility—empowerment to take control of your own life and make change. The Rockland Recovery Center will become such a learning community.

The Orienting Principles are:

Rockland Recovery: A Peer Support Learning Community is committed to the recovery of all its members through mutual support. We believe that recovery is possible. We

⁶ Prochaska, Norcross and DiClemente, *Changing For Good* (Avon, 1994), p.101.

⁷ Peter M. Lehman, "Notes on Collaborative Learning," American Sociological Association, 1997.

⁸ See, for example, Malcolm Knowles, *The Adult Learner: A neglected species*, 4th ed. (Gulf Publishing, 1990) and K. Patricia Cross *Adults As Learners*. (Jossey-Bass, 1981)

believe in the dignity and worth of each person and that each person has the strengths, capacities, and potential for recovery. This is a learning community where we can be safe and draw on each other's strengths, joys and sorrows, where we respect each other and help each other learn and grow. We believe that if we have the honesty to accept the need, the courage to hope, the willingness to learn, the strength to change, the openness to share the journey, and a commitment to celebrate our progress we can restore ourselves to healthy productive lives.

OPERATIONS

The basic strategy of the program will be the development of a cadre of trained peer support workers recruited from the membership. Some of these workers will be paid a modest stipend for their responsibilities. Workers will receive an initial training followed by continuing training/education sessions. Training will focus on education about recovery and relapse prevention and the skills identified by Copeland and Mead delivered in trainings and job shadowing at Sweetser and Amistad, as well as additional attention to co-occurring disorder programs specific to RPSDI. Initially, training will be provided through program partners including Amistad and Sweetser. Eventually, with experience, the Center will offer in-house training and continuing education while remaining in close collaboration with other resources.

Peer support workers will provide the day to day operation of the community as well as core functions such as orientation of new potential members, assisting in the operation of the programs, facilitating learning, and providing special peer guidance in other areas such as through our arrangement with the Rockland Career Center. There will be regular meetings of the peer workers to discuss issues, concerns, and help formulate plans and recommendations for the Community. They will play a key role in the governance and direction of the community as well as the continuing evaluation of the process and outcomes of the Center.

The peer support worker strategy has advantages for the workers themselves as well as for the community. For the workers it provides a sense of personal empowerment and hope and deepens and broadens their own recovery through helping others as well as through advanced recovery training opportunities. For the Community, the peer support worker strategy creates a culture of recovery, mutually supportive relationships, and collaboration, not the least of which is through modeling recovery and hope. It also provides a mechanism for developing and broadening the leadership in the community as well as vital input into the Community's conduct and development. In short, the peer support worker strategy promotes inclusiveness, broadens peer involvement and celebrates hope and restoration.

Rockland Recovery will provide a drop-in facility and learning center for adults, staffed primarily by trained peer support member workers, where members can find company and resources. **Membership** in the Community will be free and available to anyone who self-identifies themselves as in recovery or seeking recovery and makes a commitment to the orienting principles of the Community.

Each new person who comes to the Community will receive an **individual orientation** from a peer support worker. They will find out a little about the person and their situation, needs, and interests and will discuss the program and philosophy of the Community and answer any

questions. As part of this process the new person will be asked if they are willing to make a commitment to recovery and become a member.

The purpose of the orientation is to individually welcome the new person, affirm their importance, give them a sense that recovery is possible and that they are not alone, empower them by offering them choices, model the collaborative quality of the Community, and provide their first connection to the Center. In addition, the orientation process will allow collection of basic information about the new member and their needs.

Peer support workers will assist members in formulating their personal learning and development plan beginning at orientation and periodically on a continuing basis. These plans will not only help guide the member and provide a sense of progress and accomplishment but also help guide the Center as an on-going needs assessment for developing and providing programs.

There will be regular **Fellowship meetings**—peer support recovery groups—where members can check in about their lives, share their experience, strengths, hopes and challenges, and discuss topics of concern to those in the meeting. This is a model based on Zackon, McAuliffe and Ch'ien, *Recovery Training and Self-Help* (National Institute of Drug Abuse, 1993).

The Community will have on-going peer facilitated, collaborative **programs** on recovery skills and strategies, such as WRAP (Wellness Recovery Action Plan) sessions, education programs about mental illness including addiction, and a peer support training program. The Community will also provide programs on issues such as employment, housing, and self-support life skills. The Community will develop and maintain close relationships with other resources in the community so that it can be a resource center for members in search of specific assistance and opportunities. Governance and programming decisions of the Community will be through regular membership meetings.

The Center will offer drop-in and scheduled programs for those who wish to engage in directed and self-directed learning experiences. These peer-facilitated activities may include learning to prepare for stressful situations; building self-esteem; learning to recognize and manage urges, including using substances; making and keeping friends; speaking out for yourself; recognizing and managing danger signs and triggers; dealing with the effects of trauma; handling on-the-job problems; investigating and expanding social supports, employment opportunities, or leisure time skills; developing a more open recovery; and developing a recovery and wellness lifestyle. These sorts of activities will draw upon models such as those in Zackon, McAuliffe and Ch'ien, *Recovery Training and Self-Help* (National Institutes of Drug Abuse, 1993). Mary Ellen Copeland's *Wellness Recovery Action Plan program and the Recovery Workbook*⁹ will also guide program activities and strategies.

The Center's programming will be based on emerging standards of peer support including the following:

- Promotion of critical learning and re-naming of experiences.
- Providing a sense of community.

⁹ The Recovery Workbook. Practical coping and empowerment strategies for people with psychiatric disability. Spaniol, etal. Center for psychiatric Rehabilitation. 1994. Boston University.

- Flexibility in the kinds of support provided by peers.
- Activities, meetings and conversations that are instructive.
- There is mutual responsibility across peer relationships.
- Peer support is clear about and sets limits.
- Peer support involves sophisticated levels of safety.

Resource Center. Because recovery takes place within the context of real lives and real problems, members have pressing needs for housing, transportation, and employment. They may have needs for the services of mental health professionals and programs. In many cases, members lack experience and skills to locate and utilize community resources, including navigating the Human Services labyrinth, and the day-to-day skills of maintaining housing and employment. The Center will address these issues in four ways. First, the collective experience and expertise of its members will provide guidance and support. Second, the Community will develop and maintain an extensive network of connections with agencies, organizations, programs, and individuals and actively link members through these connections. Third, Peer Support Workers will be available to assist and even accompany members in connecting with resources. Fourth, the Community will offer regular workshops on accessing and utilizing resources and day-to-day skills. NAMI Maine's information and referral services will compliment these efforts. Coupled with these, we also hope to develop a local version of the excellent guidebook, developed by Alex Myhaver, *The Housing Source: Finding and Keeping the Housing You Want in Greater Portland* (Amistad, 2003).

Outreach. Because the Recovery Center has a strong commitment to improved transition from institutions to the community, the Center intends to reach out to local institutions. Depending on staffing, funding, and the availability of trained volunteers, the Center eventually intends to provide peers who can visit emergency rooms, detoxification programs, jails, and the prison to make sure information about available services is available to consumers and their families and to ease entry and discharge. Amistad's in-hospital peer support program will serve as a model for outreach activities.

Time: The Center's initial and primary focus will be on evening hours between 6 and 9, hopefully expanding to six days a week and daytime hours. The expanded hours will depend on peer staffing and finances. Evening hours are important because they are vulnerable times, especially since social norms and personal habits associate evenings with social activities, comfort, and social bonds. Thus, these hours can easily trigger feelings of loneliness, rejection, worthlessness, and hopelessness and result in crisis. Moreover, traditional mental health providers and programs are generally not available in the evenings. Finally, evening hours allow a valuable opportunity for a wider range of members to interact—for example employed and unemployed members.

ANTICIPATED OUTCOMES.

- Consumers will have increased skills in managing their lives and the symptoms and problems that effect them
- Consumers will form supportive relationships with others who are recovering from mental illness, substance abuse, trauma, and the effects of institutionalization.

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- Consumers will experience emotional healing and improved self worth through expanded “community” and improved coping skills.
 - Consumers will expand their relationships with the broader community.
 - Consumers will identify life goals and make progress in achieving these goals.
 - Consumers will decrease their episodes of crisis by building supportive and helpful peer relationships and a community.
 - Consumers leaving institutions will receive early and helpful connection to others who have experienced what they have experienced.
 - Rockland service providers and institutions will have a place to refer consumers for peer support services as well as access to consumers to serve on their boards and assist them to understand peer perspectives and improve the quality of their service delivery.

ATTRACTION AND RETENTION.

The Rockland Recovery Center will attract and retain consumers in a fashion similar to that used to establish the steering committee and prepare this proposal – outreach and ongoing development. The steering committee includes representatives from all major service providers and discharging institutions in the area. We anticipate referrals from each. The steering committee also includes many peers – who are currently involved in outreach to people with substance abuse, mental health, and criminal justice backgrounds. NAMI Maine is one of Maine’s largest providers of information and referral and will publish information about the Center in its resource directory, affiliate list, newsletter, and make phone referrals. Retention is a factor of performance. Consumers will be members of the Center, participate in its development and over time, as peer supporters, volunteers, board members, and staff. Consumers will play a variety of roles, flexibly determined based on choice, and become part of a community in which they feel safe, supported, and valued. The Center will only retain consumers if it adheres to the tenets and outcomes spelled out in this program narrative. Ultimately, it is the quality of service that retains customers.