Recovery as Radical Transformation, Peer Support as a Radical Act

A Presentation by Tom Hill at the Association of Recovery Community Organizations (ARCO) Fifth Annual Executive Directors' Leadership Conference, Arlington, Virginia, July 23, 2015.

Good morning, my friends and colleagues. It is such a pleasure to stand before you this morning. The Association of Recovery Community Organizations has come a long, long way in a very short amount of time. This is the 5th annual gathering of the ARCO Executive Leadership Academy. It was always my personal hope that this academy would eventually morph into a full-fledged grassroots leadership conference that would support the recovery movement. The recovery movement is now an overnight success that took 15 years to realize. And with things like the CARA legislation and the UNITE to Face Addiction on the National Mall on October 4, the need for leadership infrastructure development is paramount now more than ever. So while I am still hopeful for an annual conference for everyone, establishing this meeting of emerging leaders in advocacy and program development that has now met for five years demonstrates Faces & Voices of Recovery's ongoingcommitment to ARCO.

Congratulations on that and welcome to all new and returning RCO leaders!

I did a talk a couple of months ago, entitled **Recovery as Radical Transformation, Peer Support as a Radical Act.** The title alone seemed to grab everyone's attention, so I thought that I would use it as a basis to begin our discussion today. The word radical is, indeed, a provocative one. There are two related definitions of the word that I would like to explore with you today. The first definition is about going to the root and fundamentals, of forming a foundation. The second means making comprehensive and sometimes extreme change from accepted or traditional forms. To blend these two definitions, I propose that we set up a framework for our discussion that involves strategically using the fundamental and transformative power of both recovery and peer practice to make significant change in services and systems as they currently exist.

I want to share with you some *bumper-sticker wisdom* I saw on the highway several years ago. It was a directive that stated: *Comfort the Disturbed and Disturb the Comfortable*.

When I saw it, I repeated it to myself several times and thought: "That's what peer practice is. We give hope and healing to those like ourselves and, at the same time, by the very nature of what we do, we create waves of unrest in complacent and otherwise stale systems." Alright, I didn't say it exactly like that, but that is what I was thinking. I will let you think about that for a moment while I introduce myself in a very specific way that I have been taught and have taught others through the Faces & Voices message training:

Good morning, my name is Tom Hill and I am a person in long-term recovery. For me, that means that I have not used alcohol or other drugs for over 23 years. My life in recovery means much more that not using substances; it is about being comfortable in my own skin, secure in my sexuality, engaging with my family and community, accepting new roles and responsibilities, answering the call to a new sense of purpose, and moving closer to a potential that I could not have even imagined for myself before recovery. The truth is that my life is very, very full. And I am living proof not only that recovery is possible, but that our lives will only be as fabulous as we believe they can be when we have the wherewithal to get out of our own way to let them happen and evolve.

I did not always feel this way. If you were able to see me 23 years ago standing next to me today, you would notice a tremendous difference between my former and current selves. I weighed about 140 pounds soaking wet. I was consumed with self-hatred and shame. And I could not look you in the eye. I'm sure that this is no great surprise to many of you, as our pathways to addiction shared similar routes.

Because of who we are and the work we have been called to do in recovery, we bear witness to remarkable examples of transformation – in ourselves and in others – every day. Every day, we see people get connected with purpose and potential, moving towards hope, wellness, and self-realization. It is an honor and privilege to help facilitate - with all of you - this mighty transformation in individuals, families, and communities as they embrace recovery and return to life.

I am told that there are people who recover from addiction all by themselves, but I personally don't know any of them. I know that I personally stand on the shoulders of giants: those men and women who helped me up from the ashes when I crashed and burned. And from my own *lived experience*, which I have come to value in numerous and unfathomable ways, I have noticed that recovering in community affords us certain advantages. There we act as mirrors to each other's experience, hold each other accountable, acknowledge and celebrate each other's progress and milestones, and **never have to be alone again**. Because for me, addiction and isolation have always been and continue to be cozy bedmates. Above all else, a recovery community offers a sanctuary that is both a holding tank and an incubator for our personal evolution: a safe and even sacred space where onions can be peeled and where butterflies emerge; a place where we can do our recovery work, helping ourselves and others fully flourish.

When I go around the county and meet with people in the organized recovery community, I notice that there is a shorthand language that we often speak to one another. We may not all use the same words but the underlying intention is the same: recovery is a process that has radically transformed our lives in ways that we can never quite explain. We look each other in the eye and we "know." My journey may be completely different than yours, but we have both experienced the spark that ignites and transforms our lives. This "spontaneous combustion aspect of recovery" is the part that cannot be explained solely through science and medicine. However, science and medicine are quickly catching up to a holistic understanding of connections between the human condition and the human spirit. In the meantime, there is a quality about recovery that we have a difficult time articulating and are sometimes even a little embarrassed to explain to others outside our community. At least, that has been true for me. And I think that we sometimes just need to give a knowing shrug to mysteries that may not be fully explainable in the moment. Because it is difficult to explain the spirit in rational terms or even in words altogether. We just look each other in the eye and we "know and nod." Recovery is a radical transformation.

But we also need to articulate beyond our communities the intrinsic and often difficult-to-explain qualities of recovery. We cannot afford to hide behind a sense of what we think might be humility and underplay our experience and the incredible work that happens under the guise of recovery and peer services. We are learning to carry this message beyond the comfort and confines of our communities.

In the beginning of this talk, we spoke about the term radical as meaning a return to fundamental roots, of laying a foundation. So I want to talk about the legacy that was created by the Recovery Community Services Program (RCSP) grantees in 2001 when we were charged with developing peer services. At that time, SAMHSA, the TA Team, and the RCSP grantees spent a lot of time discussing what we wanted peer services to be and how we could develop them. We researched what had been established in other disciplines, like Mental Health and HIV/AIDS. More importantly, we looked at what had already been developed by the recovery community. One of the initial tenets we identified was taken directly from Alcoholics Anonymous: that when one person helps another to recover, both get helped. [Before I go any further, this statement is not in any way meant as an endorsement of AA or any 12-step group, only an acknowledgement of a useful recovery philosophy that was incorporated into our early development of peer practice.]

In addition to this fundamental philosophy, a set of principles and values were established at this time. Some of these include:

- Protecting the authenticity of lived experience of addiction and recovery and the integrity of the peer relationship
- Building on the inherent strengths of individuals, families, and communities and promoting Recovery Capital
- Building on the legacy of service, giving back, and community volunteerism
- Promoting leadership and citizenship development in all participants
- Demonstrating commitment to supporting, educating, and developing peer leaders
- Consciously using language that is non-stigmatizing, non-shaming, and inclusive to all pathways to recovery
- Moving peers away from "client status" and promoting status as participants, members, and citizens
- Developing programs that are peer-led, peer-driven, or peer-informed
- Demonstrating use of "participatory processes and systems" to ensure peer and recovery community inclusion
- Designing peer service menus that address all four types of social support (Salzer, 2002): *emotional, informational, instrumental, and affiliational*.
- Promoting guidelines for developing peer programs in non-peer organizations, and
- Articulating, defining, and moving towards recovery outcomes.

So let's go back for a minute to the idea of a person receiving help through the process of helping another. There is actually a term for this called *Mutual Healing* Basically, this means that the peer-helping process has recovery benefits to both the person receiving and the person giving help. In order for this radical equation to be fully realized, there has to be as level a playing field as possible. *Mutuality*, or *reciprocity,* can only be built upon the foundation of an *equalized power differential*. This is an important aspect of developing a trusting relationship in the peer helping process. And we need to remember this and develop strategies to protect it, especially when we use peers in environments and in circumstances in which a leveled power field can be easily tipped.

The foremost qualification for a peer leader is *lived experience*, coupled with the ability to strategically share and use that experience in ways that are helpful to others. There is a really good book on this subject called The *Wounded Healer* by Henri Nowen. The premise of the book is that

people can use the *lived experience* of their woundedness to heal others and that, through the act of helping others heal, they also undergo a personal process of healing. In other words, by and through exposing our imperfections and brokenness in a helping relationship, we move closer to becoming whole. Anybody who has done this kind of work knows about this very powerful equation. And while it may not yet be evidence-based practice, it is certainly practice-based evidence. Bottom line, we know how to recognize when it's working and we know what makes it work. And we will continue to work with and inspire our researchers and evaluators to figure out how to measure it. Just like we worked with Alexandre Laudet in 2013 to activate and publish the Life in Recovery Survey so that we could demonstrate recovery outcomes (not treatment outcomes), as identified and defined by the recovery community.

The intertwined processes of healing and recovery have a special potency with those of us who have experienced the intersections of addiction and trauma. These healing and recovery processes never quite reach completion, because there always seems to be more work to do, there is so much to recover from. But we do get better, we do feel better about ourselves, and we do move closer to holism and wellness. For the peer leader acting in a role of *Wounded Healer*, his or her most valuable asset is the very thing that makes them the most vulnerable in the role and in the practice. Because that precious vulnerability is directly linked to the source of peer power, it is everyone's job to support and safeguard it.

So I am hoping that we can agree that things like *mutuality, reciprocity, leveled power, and shared woundedness and healing* are essential ingredients that form the foundation for building trust and bonding in a peer-to-peer relationship. This foundation is what sets the peer role apart from clinical and other workforce roles like case management. And while peer leaders perform a variety of tasks in diverse settings, the foundational basis of the peer role must be held sacrosanct in order for it to be most effective. Otherwise, it will get watered down until it loses all of its unique qualities and becomes no different than any other workforce role. As more and more peer workers are ushered into non-peer environments, creating space to hold the integrity and authenticity of peer practice will be a significant challenge.

Let's switch tracks for a moment and review a little bit of what has happened since we started thinking about peer services about 15 years ago. Much has changed since then, both in the greater world and in the addiction field. The addiction field has moved closer and closer to making recovery-oriented systems of care (ROSC) a reality. Federal, state, and tribal agencies have undertaken systems-transformation efforts, with a greater understanding of addiction as a chronic condition requiring more comprehensive strategies to help individuals achieve long-term recovery and wellness. Strategies such as recovery management have been complimented with structures that allow individuals to choose from a menu of services and supports, including peer recovery support services, according to what they need at particular moments over a lifetime. The organized recovery community has made significant contributions to the development of ROSC, especially as they have paralleled the development of peer practice.

As ROSC initiatives were being introduced and developed in states, counties, municipalities, and tribes, two important events unfolded on a national level. The Mental Health Parity and Addiction Equity Act (2008) and the Affordable Care Act (2010) created both opportunities and challenges for the addiction field to become an integral part of the healthcare system. Efforts to integrate addiction

services and systems with mental health and primary care have required a tremendous amount of thinking and adjustment. Addiction treatment and prevention have traditionally operated independently of the healthcare system, creating the need for new infrastructures and capacity, both on systems and services levels.

In the midst of all of this change, the introduction of peer services as a component of expanding service menus and peer workers into the expanding workforce has moved from an idea to a reality. To meet this new demand we have had to accelerate the development of peer services to a place of readiness in meeting service and workforce demands. We have also had to be present at tables where policy and programming decisions are being made about when, where, how, and why to use peer services and peer workers. And we sometimes learned the hard way that when we are not included in official decisions, the outcomes are often not in our best interests.

I am going to take this opportunity to share with you a current trend taking hold in too many places across the country. As State certification boards and offices of Medicaid directors are trying to figure out qualifications for peers and processes for reimbursement of peer services, decisions are being made about that could have long-term repercussions in the organized recovery community. In too many cases, the qualification of "lived experience" is being dropped from the definition of "peer." Listen to me for a second: I don't care if you believe that a peer needs to be in recovery or not. The bottom line is that we fought long and hard to establish lived experience as a valuable component of peer services. And when that gets dropped, I predict that it will not be long until we are out of the picture altogether. Why, because we are still stigmatized. Why, because the professional world thinks that we can be too troublesome, you know, all that messy recovery stuff. Why, because it has happened before. Think about the history of treatment, which was initially developed by the recovery community and then became disconnected from that community–disconnected to the point where treatment counselors are strongly discouraged or forbidden to even reveal their recovery status.

Further, another ugly snake is once again raising its ugly head: the criminal backgrounds of peer coaches and peer leaders. Those folks on credentialing boards and state houses just don't seem to get it. And there are states that are addressing the barrier by reinforcing it, making it difficult to impossible for a person with a criminal justice background to get employed as a peer coach. Our practical message to them needs to be that such mandates will knock out a good 75% of the intended work pool. Our more urgent message is that such barriers are unacceptable.

Early on, we tried to create a firewall by creating an accreditation system for RCOs and peer programs that would ensure the integrity and authenticity of peer practice. We knew that if we did not create our own standards, that they would be created for us and not always in our best interests, as I have just described. We also wanted the focus of accountability to be on the organization and program, rather than the individual practitioners, and to make room for the amazing legacy of service and volunteerism in our communities. And of course, the fruit of many hard years of doing the groundwork with recovery community leaders, many of whom are in this room today, culminated in CAPRSS: the Council on Accreditation of Peer Recovery Support Services. We are fortunate to have Liz Burden here today, who did the major engineering of CAPRSS and will be presenting workshops on it this afternoon.

Throughout this exciting and chaotic time, there has emerged an unwavering truth: that what we have created has immense value. We have known all along what others are just beginning to figure out: that the transformative power of peer practice – especially when added to other services and supports - can help people get and stay better. Our lived experience can now be looked upon as an asset and an element of expertise, rather than something that has been traditionally regarded as immoral, shameful, and stigmatized. As we are now invited to participate in the institutions that used to shun us, we need to accept our new invitations with caution, vigilant to protect the radical and fragile essence of what we have created, and careful to create the right fit of where, how, and why peer services are placed.

Working in these new environments is requiring us to become more bold and proactive in our approaches. We are learning to better articulate the value of peer services and the importance of the contexts in which they are delivered. And just as we promote empowerment and ownership of peers through peer practice, we need to establish that same sense of empowerment and ownership for ourselves. This is not easy and requires some substantial groundwork. Community people need to be trained in how to work in and with professionally-driven services and systems. Any many systems administrators and service professionals need training in how to work effectively with nonprofessionals, laypeople, and community leaders. And we must be careful that we are not shy about voicing our concern and that we are not so easily seduced by our access to powerful systems.

One of the major challenges in implementing a ROSC has been how to authentically bring in community stakeholders so that they are in integral part of the process from the very beginning to the end. One of the most successful ROSC efforts took place in Philadelphia under the leadership of Dr. Arthur Evans, who utilized the organized recovery community – namely PRO-ACT - as a major player from the start. Ten years in the making and still in progress, Philadelphia is a now world-renowned example of a ROSC systems transformation and Dr. Evans is a sought-after speaker to explain the philosophy and science of ROSC and how they went about accomplishing it. When Dr. Evans speaks about systems change, he highlights three different approaches

- **Additive:** adding peer supports to the existing treatment system
- **Selective:** peer practice and administrative alignment with selected parts of the system [e.g. pilot projects]
- **Transformative**: Cultural, values-based, change that drives practice, community, policy, and fiscal changes in all parts and levels of the system. Everything is viewed through the lens of and aligned with recovery-oriented care.

So let's stop for a moment and consider a few things. At the beginning, I explained two definitions of the word radical and I promised that we would discuss blending the two. So we have discussed radical as it applies to the roots and foundations of peer practice, as well as the radical nature of things like *mutual healing* and *wounded healers*. And now we are starting to talk about the potential of peer practice to make radical changes in existing services and systems, about making significant contributions to Recovery-oriented Systems of Care. And I have walked us through some of the changes that have occurred in recent years and how, in many ways, they have created a "perfect storm" for peer practice and peer services. So, when we consider Dr. Evans' three types of change, why would we settle for anything less than transformative?

Let's think about that for a minute. One reason is that transformative systems change is a lot harder. It is much easier to add on peers to an existing program or peer leaders to an existing workforce or to select an isolated area to pilot a peer program. And while a pilot effort can be a transitional step towards full transformation, adding a loosely attached system appendage does not constitute systems transformation.

The bottom line is that our current systems NEED transforming because their design is outdated and archaic: it does not comport with what we know about addiction and recovery today. The system is designed to treat addiction as an acute and not a chronic condition and lacks the capacity to help individuals, families, and communities sustain long-term recovery, to help enough people get and stay well. So we can add peer workers to the existing treatment system, and they will do little more than assist treatment providers, act in the case manager roles, or provide something that is vaguely referred to as aftercare (after-what?).

The alternative is that we place peer workers as change agents in treatment settings - as well as other non-peer settings like Drug Courts, jails and prisons, child welfare agencies, and emergency rooms – to help them become recovery-oriented and more adept at helping people attain long-term recovery and wellness. In order to do this successfully, we need to be intentional in our design and planning and have as many diverse stakeholders as possible on transformation teams – just like they have done in places like Philadelphia. Adding peer practice to professional and clinical practice needs to be done respectfully, carefully, in stages, and with all parties adequately trained. If the transformation is rolled out successfully, new roles and clusters of complimentary roles will emerge, new programs will unfold, and new measures of program success and recovery outcomes will surface. If successful, we will transform the role of clients and patients from passive recipients of services to program participants, community members, and citizens, fully engaged in their own recovery and wellness and choosing the services and support they need to get there. And if we do make the choice to participate in all of these diverse settings, we never forget the community aspects of peer work and keep the home fires burning in community settings.

And the defining questions of success will be:

- Do programs build on the strengths and value the experience of people in and seeking recovery?
- Do program participants have the opportunity to make choices based on a wide array of services and supports?
- Do more people get better, achieve long-term recovery, and have active and self-determined lives?

While we are accepting the invitation to *join* the institution, let's take full opportunity to *transform* the institution. As we graciously accept our invitation to the party, let's volunteer to be on the decoration and refreshment committees, let's suggest other potential invitees, let's offer some new music and dance steps. In time, we can make it a better party, open to new participants and new ideas, and create an entirely new event. In other words, let's blow the whole damn thing wide open. And let us not forget our resolve to be ever-vigilant. We are here to ensure that more people get into and stay in long-term recovery, that more people get and stay well.

As I have noted already, there is an entire system out there that is outdated. It is based on stale, old ideas that presently do not work, if they ever did. And it is our tireless work as watchdogs, advocates, and change agents to continually step up and speak out. It is unacceptable that our folks are offered short and inadequate episodes of treatment and then blamed when they relapse. It is unacceptable that our folks are still locked up for having an addiction, and then persecuted again when they leave incarceration after serving their time and enter the community. It is unacceptable that our folks are dying of addiction and overdoses that can and should be prevented. It is indeed time to fight back to summon all of our outrage of the way we have been and continue to be treated. It has been proven time and time again that if we do not stand up for ourselves, both as individuals and as a community, that no one else will.

We are currently in the midst of a sweeping opioid epidemic. Let's face it: between us, we know that, although it is spiked, it has been around all along. It is getting current media and public attention because it is now taking place in middle class, white, suburban communities. If that is what it takes to get attention, we'll take it and use it and run with it. We will use it to uncover the greed of Big Pharma, to talk about pain management, to talk about the various ways that people get addicted that have nothing to do with ABUSE, and everything to do with vulnerability. We will talk about how unleashed addiction has been devastating our communities for decades and, more importantly, we will talk about how recovery turns things around. And, as people in long-term recovery, we are making ourselves available as experienced and knowledgeable go-to experts. And we will proudly state that recovery is not only possible, IT IS AN EXPECTATION. Maybe we can use this new attention as a pivot point to exclaim, with a sense of urgency, that addiction is tantamount to death and that recovery is a compelling way to address it. And as we think about this, let us please remember and pay tribute to our friend and colleague, a tireless advocate and warrior, Jimmy Gillen who left the planet earlier this week after a long and courageous fight with cancer.

We could go into much greater detail with these ideas and questions, but we only have a short time together for this session so we have to be content with painting the treetops. So far we have talked about things like *mutual healing, wounded healers, change agents, and systems transformation*. I want to leave you with a final term: *Disruptive Innovation*.

Disruptive Innovation is a term that was introduced a number of years ago in the world of business and technology. Here's a definition: *A disruptive innovation is an innovation that helps create a new market and value network, and eventually disrupts an existing market and value network, displacing an early technology.*

Basically, it means that something is so new and innovative, becomes so widely adapted, that it blows it predecessors out of the water. A recent example might be the smart phone. In a very short time, the smart phone has not only replaced all other cell phones, but has radically changed the way we use and regard computers, the way and speed in which we access information, the way we communicate, the way we behave in public spaces. It has created disruptions everywhere by the audacity of its innovation.

What if we said: Peer Practice has created disruptions everywhere by the audacity of its innovation?

If we stop to think about things, this is our moment. The recovery movement is gearing up in full swing and all of the planets are in alignment for the elevation of peer services. How we choose to play this defining moment for ourselves is up to us. Do we want to give away what we have created and risk it being watered down, adulterated, and changed into something resembling or promoting the status quo? Or do we take ownership of our creation, develop it to its highest state, and offer it as a vehicle of recovery-oriented transformation?

I think that we have worked far too hard and come way too far to do anything but the latter. Let's keep our best interests in the forefront and not allow them to be undermined. Our proudest moment has yet to come, but it is surely on its way. More people in sustained long-term recovery, more families healing together, more communities well and whole. And peer practice can be and is a vital component in this great turning.

Comfort the Disturbed and Disturb the Comfortable.

Thank you and I hope you enjoy the rest of the leadership academy. Continue to do the groundbreaking disruptive and innovative work that you do.