

Substance Use Approaches Among Peer Support Specialists in Community Mental Health Early Psychosis Programs

Vanessa Vorhies Klodnick¹, Brianne LaPelusa¹, Samantha J. Reznik¹, Rebecca P. Johnson¹, Neely L. Myers^{2, 3}, Alicia Lucksted⁴, Deborah A. Cohen^{1, 5}, and Molly Lopez¹

¹ Steve Hicks School of Social Work, Texas Institute for Excellence in Mental Health, The University of Texas at Austin

² Dedman College of Arts and Sciences, Southern Methodist University

³ Department of Psychiatry, University of Texas Southwestern Medical Center

⁴ Department of Psychiatry, Division of Psychiatric Services Research, School of Medicine, University of Maryland

⁵ Department of Psychiatry and Behavioral Sciences, Dell Medical School, The University of Texas at Austin

Objective: Substance use (SU) is common among adolescents and young adults, including those experiencing early psychosis. Coordinated Specialty Care (CSC), a community-based multidisciplinary team-based service model, is increasingly used to support people experiencing first-episode psychosis. In addition to prescribers, clinicians, and vocational specialists, CSC includes peer support specialists who use their own living/lived experience with mental health and treatment to engage and support young people with their recovery goals. Peer support is also foundational in SU recovery. However, little is known about how peer support specialists navigate client SU in CSC. The purpose of this article is to detail CSC peer support SU practice. **Method:** Informed by community-based participatory research methods, a PhD-level qualitative researcher and a former peer support specialist conducted virtual interviews with 20 CSC peer support specialists. A multidisciplinary team including researchers with lived mental health experiences thematically coded interview transcripts. **Results:** A spectrum of CSC peer support specialist SU responses emerged: (a) leverages lived SU experiences; (b) does not explore SU with clients; (c) shares client SU information with the CSC team; (d) educates, mentors, and advocates; (e) shares SU consequences and/or challenges substance use; (f) nonjudgmental, nondirective SU exploration; and (g) promotes harm reduction. **Conclusions and Implications for Practice:** CSC peer specialist SU practice is influenced by several contextual tensions that must be better understood and addressed in future research to improve peer SU practice. Study findings speak to practice nuances that are helpful for CSC peer support training and supervision.

Impact and Implications

This study finds that peer support specialists on early psychosis Coordinated Specialty Care teams vary in their experiences with substance use (SU) recovery as well as their perceptions of and responses to client SU. Training in nonjudgmental SU exploration, harm reduction strategies, and SU recovery story matching with client SU perceptions may increase peer specialist effectiveness in validating and supporting clients with their SU goals.

Keywords: Coordinated Specialty Care, peer support, substance use, first-episode psychosis, qualitative research

This article was published Online First July 25, 2024.

Vanessa Vorhies Klodnick  <https://orcid.org/0000-0002-3311-8203>

Research reported in this publication was supported by the National Institute of Mental Health of the National Institutes of Health under Award Number R01MH120599. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

This work is licensed under a Creative Commons Attribution-Non Commercial-No Derivatives 4.0 International License (CC BY-NC-ND 4.0; <https://creativecommons.org/licenses/by-nc-nd/4.0>). This license permits copying and redistributing the work in any medium or format for noncommercial use provided the original authors and source are credited and a link to the license is included in attribution. No derivative works are permitted under this license.

Vanessa Vorhies Klodnick played a lead role in conceptualization, formal analysis, methodology, project administration, supervision, validation, writing—original draft, and writing—review and editing and a supporting role in data curation, funding acquisition, and visualization. Brianne LaPelusa played a

lead role in data curation, a supporting role in methodology, and an equal role in formal analysis, validation, visualization, writing—original draft, and writing—review and editing. Samantha J. Reznik played a supporting role in validation, visualization, and writing—review and editing and an equal role in formal analysis. Rebecca P. Johnson played a supporting role in project administration and writing—review and editing and an equal role in formal analysis and validation. Neely L. Myers played a supporting role in validation and writing—review and editing. Alicia Lucksted played a supporting role in validation and writing—review and editing. Deborah Cohen played a supporting role in conceptualization, formal analysis, project administration, validation, and writing—review and editing. Molly Lopez played a supporting role in conceptualization, project administration, validation, and writing—review and editing.

Correspondence concerning this article should be addressed to Vanessa Vorhies Klodnick, Steve Hicks School of Social Work, Texas Institute for Excellence in Mental Health, The University of Texas at Austin, Austin, TX 78701, United States. Email: vanessa.klodnick@austin.utexas.edu

First-Episode Psychosis and Coordinated Specialty Care (CSC)

Approximately 75% of psychotic disorders onset between ages 18 and 25 (Kessler et al., 2005), impacting approximately 100,000 people annually in the United States (Anderson et al., 2019). Psychotic disorders include any psychiatric disorder that includes the experience of symptoms with psychosis (i.e., schizophrenia spectrum disorders, mood disorders with psychotic features; American Psychiatric Association, 2022). These conditions can be debilitating and are associated with social isolation, poverty, homelessness, psychiatric hospitalization, justice involvement, and disability benefit use (Charlson et al., 2018; Rosenheck et al., 2017; Velthorst et al., 2017). Recent U.S. research and policy efforts have led to the development of Coordinated Specialty Care (CSC; Heinssen & Azrin, 2022) to improve outcomes. CSC mobilizes a team to deliver evidence-based psychiatric, clinical, vocational, and peer support in the community (Dixon et al., 2015; Heinssen et al., 2014; Mueser et al., 2015). CSC typically includes (a) a medication prescriber (i.e., psychiatrist or psychiatric nurse); (b) one or more licensed clinicians trained in psychology, social work, or counseling; (c) a supported education and employment specialist; (d) a team leader who is typically clinically licensed; and (e) increasingly, a peer support specialist (Powell et al., 2021). Today, there are over 360 U.S.-based CSC teams (Heinssen & Azrin, 2022).

Substance Use Among CSC Clients

Approximately 50% of CSC clients meet the criteria for both substance use (SU) and psychotic disorders (Cather et al., 2018). Comorbid SU disorders among individuals with first-episode psychosis are associated with worse outcomes, including increased symptom severity, service disengagement, psychiatric hospitalizations, justice involvement, unemployment, homelessness, and poverty (Abdel-Baki et al., 2017; Colizzi et al., 2016; Fraser et al., 2023; Oluwoye et al., 2019; Ouellet-Plamondon et al., 2017; Patel et al., 2016; Schoeler et al., 2017; Weibell et al., 2017). Cannabis is the most commonly used substance among young people with early psychosis (Lange et al., 2014). One study of CSC participants ($N = 938$) found that 39% reported cannabis use at CSC enrollment, and 33% used cannabis (at least once every 90 days) in their first year of CSC (Marino et al., 2020). Cannabis use is linked to psychosis onset and progression, with those links related to age at first use, frequency, and potency (Di Forti et al., 2014; Large et al., 2011; Leeson et al., 2012; Marconi et al., 2016; Myles et al., 2016). Individuals who continue cannabis use after psychosis onset have increased symptom severity, psychotic episodes, and psychiatric hospitalizations compared to those who never used or ceased use after psychosis onset (Hasan et al., 2020; Schoeler et al., 2016).

To date, there are no evidence-based SU interventions for individuals with first-episode psychosis, although research suggests that interventions (e.g., cognitive behavior therapy, motivational enhancement strategies) are helpful (Substance Abuse and Mental Health Services Administration, 2019). Best practice suggests that individuals using substances should be included in CSC programs, and SU intervention should be integrated with CSC services (Bello & Dixon, 2022; Substance Abuse and Mental Health Services Administration, 2019). CSC SU interventions should include shared decision making, harm reduction, and efforts to address both mental

health and SU symptoms concurrently using models such as Integrated Dual Disorders Treatment and Behavioral Treatment for Substance Abuse in People with Serious and Persistent Mental Illness (Bello & Dixon, 2022; Myers et al., 2023). Widely adopted CSC models, for example, OnTrackNY (Bennett et al., 2018) and NAVIGATE (Penn et al., 2020), include SU practices that draw from Integrated Dual Disorders Treatment. Despite these resources, a recent qualitative study across five U.S. CSC teams found staff ($n = 20$) felt SU services were critically lacking in CSC (Stokes et al., 2022). Historically, SU and mental health treatment have been separated (Mueser et al., 2003). Limited research explores current CSC SU practice from a CSC staff perspective.

Peer Support

The peer support specialist occupies a key role in many CSC teams across the United States (DuBrul et al., 2017). Peer specialists are mental health professionals who use their living/lived experience with mental health conditions to promote client engagement, hope, empowerment, and goal attainment (Shalaby & Agyapong, 2020). Most states offer peer specialist training and certification programs (Peer Recovery Center of Excellence, 2023). Peer specialists follow national and state peer codes of ethics (National Association for Alcoholism & Drug Abuse Counselors, 2023). CSC-specific peer support values and practices are detailed in a public practice manual (DuBrul et al., 2017) and qualitative research (Walker et al., 2023).

There is a long history of peer-to-peer, community-based SU treatment and support. For example, 12-step programs include individual support from someone further along in their recovery (i.e., sponsorship) and community group meetings where peers share their SU recovery stories and witness each other's recovery journeys (White, 2014). Given the many intersections between peer support in mental health and SU treatment, and the prevalence of comorbid psychosis and SU, exploring CSC peer specialist approaches to addressing SU is an important part of improving SU recovery services within CSC.

Objective

This study examined CSC peer specialists' responses and actions related to client SU. As an important note, our team believes that all CSC team members must support clients regarding SU. Given CSC peer specialists increasing presence, it is critical to understand their experiences to shape CSC peer support training and to improve CSC services.

Method

This study was approved by the Institutional Review Board at The University of Texas at Austin. This study employs elements of community-based participatory research methods (Oscós-Sánchez et al., 2021).

Site, Eligibility, and Recruitment

To be eligible, individuals had to be peer specialists on a CSC team for at least 3 months. Eligibility criteria did not include personal experience with or recovery from SU. From 2021 to 2022,

participants were recruited from Early Psychosis Intervention Network in Texas, an National Institute of Health-funded learning health system with 15 CSC programs in the state of Texas (Cohen et al., 2023). Study recruitment flyers were shared with sites via meetings and newsletters. Interested peers contacted the study coordinator to review and sign the consent form. To increase the sample size and include perspectives beyond Texas, flyers were shared with the South Southwest Mental Health Technology Transfer Center Peer Support Learning Community and the Psychosis-Risk and Early Psychosis Program Network listserv.

Data Collection

A PhD-level qualitative researcher and a former peer specialist with lived mental health and SU recovery experiences developed interview questions and conducted interviews via Zoom, either together or separately. Interviews lasted 45–60 min. Questions included How does SU come up in your team's work with young people? What is your perspective on young people's SU? How do you provide support around addressing SU? What impact did it have? Why? Participants were not asked directly about their personal experiences with SU. Participants received a \$50 virtual gift card.

Data Analysis

To analyze the data, the research team used reflexive thematic analysis, in which existing theories and constructs (in this study: peer support, SU, CSC) are held in mind during code development (Braun & Clarke, 2023). While collecting data, the two interviewers met regularly to discuss and reflect on similarities and differences between participant perspectives and actions, generating an extensive analytical memo containing rich descriptions of preliminary themes related to the study's purpose—to better understand CSC peer specialist SU practice. After interviews, the former peer specialist team member downloaded, proofread, and deidentified transcripts. Our diverse coding team included one former CSC therapist and early psychosis researcher, one former multidisciplinary adolescent/young mental health treatment provider, one young adult former peer support specialist with lived mental health and SU experience, one qualitative mental health services researcher, and one mental health services researcher with extensive experience of adolescent/young adult service implementation and program evaluation across Texas. The five team members individually open-coded interviews based on analytic questions, identified related exemplar excerpts, and met multiple times to discuss codes, group/regroup codes, and develop higher order themes iteratively. The team thematically coded for types of substances discussed (e.g., alcohol, cannabis, methamphetamines) and participant actions related to SU (e.g., referral to SU specialist, SU recovery story sharing, nonjudgmental SU exploration). The coding team then discussed and identified emerging themes with the initial coding memo themes and used Microsoft Excel to organize themes and exemplary quotes by participant experiences and characteristics, for example, in personal SU recovery; not in SU recovery; personal SU but not in SU recovery; and in either an urban, suburban, or rural setting. Findings were well received in multiple 2023 academic and practice community presentations and validated and refined with two psychosis and SU research experts.

Findings

Participant Demographics

Twenty-three CSC peer specialists were screened; 20 consented and completed an interview; three did not respond to multiple contacts after initial interest. Fourteen were on Texas CSC teams, while others were from Illinois ($n = 2$), North Carolina ($n = 1$), Florida ($n = 1$), Arkansas ($n = 1$), and Louisiana ($n = 1$) CSC teams. Participants were from urban ($n = 6$), urban–suburban ($n = 5$), rural/suburban ($n = 3$), and rural ($n = 6$) geographic areas. Time in CSC peer roles ranged from 3 months to 4 years. Five held other peer roles before joining CSC teams. Fourteen were full time on CSC teams; four were full time but split between CSC and another program, and two were part time. Just over half ($n = 11$) had completed their state's peer support certification process; two were certified in drug and alcohol treatment. Eight described being in personal SU recovery; eight did not describe personal nor a SU recovery story; four disclosed personal SU but not as problematic (Table 1). Participant geographic (i.e., urban, urban–suburban, rural/suburban, rural) and SU experience descriptors (from Table 1) are included below with exemplary quotes.

CSC Peer Support Approaches to SU

Participants described approaching and responding to CSC client SU in a variety of ways, which we grouped and mapped on a spectrum, displayed in Table 2. The approaches are not ordered by quality but rather reflect different practices employed depending on contextual factors, for example, relationship with a client, substance type disclosed, situation, context, beliefs about and personal experience with a substance, and/or recovery from SU. Participants described the peer support services they provided as primarily “individual,” meeting with clients 1:1 in the community, in client homes, at their office or clinic, and via phone and video calls. One participant described facilitating support groups for multiple CSC clients based on an SU relapse prevention curriculum and two mentioned accompanying clients to 12-step support groups within the community.

Leverages Lived SU Experiences

Several participants felt having personal experience with SU was critical to providing effective peer support to CSC clients regarding SU. They described the importance of having “hit rock bottom” to truly relate, deeply validate, and empathize with CSC clients experiencing SU-related struggles.

Table 1
Participant SU Experiences

Code	Definition
SU recovery ($n = 8$)	Disclosed personal SU recovery story; described self as being in recovery from SU
SU but no SU recovery ($n = 4$)	Disclosed personal SU experiences but did not describe having an SU disorder or being in recovery from SU
No SU ($n = 8$)	Did not disclose any personal SU experiences

Note. SU = substance use.

Table 2
CSC Peer Support Specialist Substance Use Approaches

Approach	Example
1. Leverages lived SU experiences	• Uses own experiences to empathize and validate CSC clients with problematic SU • Provides SU recovery perspective on the CSC team
2. Does not explore SU with clients	• Does not explore SU when it comes up • Does not share client SU information with the team
3. Shares client SU information with the CSC team	• The CSC team refers clients out to SU-specific treatment
4. Educates, mentors and advocates	• Teaches about SU effects and shares methods to prevent SU-related struggles • Applies AA/NA sponsorship approach • Advocates for CSC clients' SU-related needs to the CSC team
5. Shares SU consequences and/or challenges SU	• Discusses SU risks • Shares how SU has negatively impacted their life • May tell young person to stop using
6. Nonjudgmental, nondirective SU exploration	• Listens and explores together in a nonjudgmental way • Promotes client voice and choice • Shares from own experiences to reflect and validate
7. Promotes harm reduction	• Helps identify and use harm reduction methods and resources • Supports and celebrates SU goal setting

Note. CSC = Coordinated Specialty Care; SU = substance use; AA = Alcoholics Anonymous; NA = Narcotics Anonymous.

Unless you have lived and living experience, you really don't qualify as a peer support specialist. ... You're not going to connect with a client unless you have that experience. I mean, how do you know what another client has gone through with depression, mental illness, alcohol or drugs unless you've been out there in the streets, and you've been doing drugs? You've been an alcoholic? You can't connect with the client. You don't know what it feels like to be homeless. You don't feel know what it feels like to hit rock bottom. (P13; SU Recovery; Urban)

Some, in particular those with an SU certification and with lived SU recovery experiences, believed it was their responsibility to ask about and address SU because no other staff on their CSC team had SU expertise:

They [CSC team members] don't really talk about it [SU] a lot. They more so talk about the mental illness aspects. And if it [SU] does come up, the psychiatrist will give his little tidbits. But I'm the one that does talk about the recovery part ... because I'm the one that has life experience, I've been through that and stuff like that. I'm basically the best they have—my alcoholism and drug addiction. (P8; SU Recovery; Rural)

Does Not Explore SU With Clients

Participants varied in whether they felt they were supposed to, could, or should ask clients about SU. Some did not explore or avoided discussion of SU. Here, a participant describes his thought process after asking a new client what he does for fun on weekends:

His answer was that he would want to smoke pot and do a cookout with his buddies. And because it was the first meeting, I just kind of brushed it under the rug. But I don't know, going forward I definitely want to be a good peer and I need to be addressing that on some level and trying to help people to quit. (P2; No SU; Urban)

Feeling hesitant to discuss SU appeared related to not having personal experiences with SU recovery, as well as when clients discussed more stigmatized and/or unfamiliar substances (e.g., "injecting drugs, smoking crack, using meth"). Cannabis was the most frequently discussed SU, followed by alcohol, heroin,

methamphetamines, cocaine, prescribed medications (e.g., amphetamines, painkillers), fentanyl, and caffeine. Participants generally wanted more information about different types of substances and effective ways to address SU: "I would love to hear more about it [SU] on a clinical level, because we are not substance use experts, I will say that" (P5; No SU; Urban). And "I don't feel like I'm informed. And I would like to be able to help somebody with substance abuse much more efficiently that I am" (P3; No SU; Rural). Some believed that asking clients directly about SU could be interpreted as offensive, parental or clinical, and waited for clients to bring SU up: "I kind of let them [client] bring [SU] up first. I don't ask them—they did you used to do drugs? Or something like that" (P9; SU but no SU Recovery; Rural).

Shares Client SU With CSC Team

Most described that it was common CSC practice to share problematic client SU with their team if they learned about it. This sharing often led to client referral to SU treatment within or outside of their agency if the SU was determined as problematic. Participants explained that SU is "not a disqualifier [for CSC]. We ... obviously want to help them to be able to recover" (P12; SU Recovery; Rural), and "We will continue to work with them [clients] and refer them to the substance abuse program that we have" (P3; No SU; Rural). Some participants lamented a lack of available and effective SU treatment options. One participant strongly felt that individuals should receive in-agency SU treatment that aligns with CSC principles.

[In-agency SU treatment] is better than doing Rehab and better than doing the 12-Step programs. ... People feel like they're a sentence rather than a treatment. Especially here, this is Texas, they're faith based. That gets in the way with a lot of my clients. ... I think they condemn people to having a problem and a disease as something that is permanent for the rest of your life when in all actuality it really isn't, you can overcome it. (P9; SU, but no SU Recovery; Rural)

Educates, Mentors, and Advocates

Participants emphasized that educating and empowering CSC clients to make decisions about their SU were critical peer support

practices. Participants varied in how they “educated” clients about SU risk. One used SU’s self-help workbook activities in a client group she hosted weekly. Others shared their own SU experiences and different methods they had used or observed others using to prevent SU relapse. Some looked up SU information on their own to share with clients or searched the internet for SU information with clients. A few described mentoring clients in achieving their SU goals through applying Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) sponsorship practices. Here, a participant described how he is successful in building strong working alliances with clients:

Because I’m an alcoholic and I also sponsor clients in AA—basically it’s the same dynamic as sponsoring clients in AA. And sometimes recovery is a part of relapse or relapse is part of recovery. (P8; SU Recovery; Certified SU Provider; Rural)

Most emphasized the importance of exploring SU risk while also sharing helpful tools and practices along the way.

What we do as Peer Educators is we don’t push or coerce people. We don’t shame them because it’s very counterproductive. A lot of what I’m trying is to teach people self-compassion and talking through what they’re doing and maybe understanding in a way that they don’t feel shame, like maybe they get to the point where they’re discussing doing something different. (P5; No SU; Urban)

Several with lived SU recovery experiences supported CSC clients in connecting to in-community peer-to-peer support meetings (e.g., AA; NA). Many described how a critical part of their role was advocating for client needs during team meetings, which included serious SU-related needs when they came up.

If there’s an individual that is using substances really badly, like meth or crack or even marijuana, but mainly the harsh ones, heroin. I bring it up [with team]: ‘This client continues to use meth and disappears and then comes back and is not taking their medicine and is showing signs of hallucinations.’ My suggestion is to get them into a treatment program here because we have an outpatient program. (P1; SU Recovery; Certified SU Provider; Urban)

Shares SU Consequences and Challenges SU

Participants varied in the extent to which they perceived SU as dangerous and/or felt ethically responsible for addressing client SU. Several with personal SU recovery experience emphasized both respecting clients’ right to self-determination while also informing clients of SU risks.

We suggest to them [clients] that it’s probably not the best idea [using substances], but we don’t tell them to do that. We suggest to them that it doesn’t help, and the best decision is on them. I usually tell them that if you’re keeping using the substances with your situation, that the worst scenario could happen, are you okay with it? And then, if they’re okay, then they’re okay. And sometimes they’re like I’m not okay with this. ... I’m not going to keep taking drugs. And, then we can work on those kinds of things. (P6; No SU; Rural)

Several participants felt it was ethically critical to share their personal negative SU experiences, to warn CSC clients of potential harm, so that clients could make informed decisions. For example:

Until you hit rock bottom, you’re not going to be like oh, they were right. ... Like me, I went to jail and ... being in jail is a mental struggle because you don’t know what’s going on. You cannot talk to your

parents. You can’t talk to anyone. You’re just there and it’s hard. That’s one of the examples that I give my clients: You don’t want to be there. ... The only person that is going to get hurt is going to be you. ... Believe me, being in jail is not the place that you want to be. (P14; SU Recovery; Urban/Suburban)

Most commonly, participants directly challenged client SU in relation to prescribed medication for early psychosis: “How is your medication going to work when you’re throwing other chemicals in the game?” (P10; No SU; Rural/Suburban). Sentiments like these came from participants with and without SU recovery histories.

Nonjudgmental, Nondirective SU Exploration

Many participants emphasized the importance of being nonjudgmental, including those who provided personal consequences associated with SU. Participants emphasized that to provide nonjudgmental SU support, one needs strong self-awareness of one’s own perspectives about SU, what has influenced them, and when to share one’s perspectives (or not) to protect and support CSC clients.

The most important part is understanding your own biases. I come into spaces a lot where substance use can be triggering for me, and I have my own perceptions around certain things just because of own experiences I’ve had in my life. But I am very aware to make sure not to impose them on other people that are taking drugs and to look at it as a more educational, like what does this do? (P15; SU, but no SU Recovery; Urban)

Sometimes, just letting a client know they too had struggled with SU was sufficient to start a conversation and convey nonjudgement.

But, if they’re going through something, I’ll say, “hey I did that too, and we could try this.” It’s more like I know where they’re coming from in a very nonjudgmental way because that’s one of the bonuses—they know I’ve been there and I feel it. I just let them find their way as long as it’s positive in some way, even if it’s just positive in making them feel better or whatever. (P12; SU Recovery; Rural)

Participants found this combination of being authentic, nonjudgmental, and using one’s story thoughtfully central to discussing SU with CSC clients. For example, one said: “We have certain clients that use marijuana as treatment ... they [CSC team] don’t condemn them, they kind of let it be. They do talk to them about it, but they kind of let it be unless it ... becomes dangerous or becomes debilitating in any way (P9; SU, but no SU Recovery; Rural).” This emphasis on being nonjudgmental and authentic appeared to come from both peer support training and their own lived experiences, including stigma related to SU. One described how that can manifest:

Say that person says: ‘I started using drugs and then I started hearing voices and I only hear voices when I do drugs.’ Then if everybody else knew, they would think, ‘You’re just a drug addict, you don’t actually have any mental health issues,’ and things like that. That’d be a real negative because when you hear things—whether it’s drug induced or it’s just part of your chemical imbalance from birth—you’re still hearing things, and it’s quite upsetting. So, the help is still needed, and there’s still a huge stigma about substance abuse. (P12; SU Recovery; Rural)

Peer support may include educating clients and CSC teammates about SU-related stigma to interrupt it. One participant shared: “It is

just all about that education- sharing my experience with those who have drug-induced psychosis ... [to convey that] you're not bad for doing it. You're not bad" (P10; No SU; Rural/Suburban).

Harm Reduction

Participants described several harm reduction methods, including partnering with clients to explore why, when, and how they engage in SU; using open-ended questions to encourage safer SU habits; and addressing what is leading to SU. Often participants learned that client SU was prompted by trauma, pain, family and peers, community, anxiety, and/or boredom.

So, we have to remind ourselves, even though we don't agree with the way they're doing it doesn't really technically make it wrong. But we do want them to be as safe and healthy as possible. So just taking away the judgment and realizing that letting them know, 'Hey, why are we actually doing this? Why do you smoke weed? What are you actually getting out of it? And then coming up with healthier ways to replace what they're trying to control [SU] with. (P4; SU Recovery; Urban/Suburban)

Most participants said that while they would not insist on abstinence, they hoped to help clients move toward gradually decreasing problematic use (and increasing safe use in the meantime):

In my peer training it was making it clear that you don't have to stop cold turkey, it could just be gradually decreasing the amount and we don't have to shame them for using or anything. If it's occasionally, it's whatever. And, then just offering support and resources about what they're using. (P20; SU Recovery; Urban/Suburban)

A few participants cited the importance of helping CSC clients develop SU goals and celebrating goal attainment.

It's goal oriented. Orientating [sic] to their goals and working to get to where they realize, 'Hey these are my goals.' Usually, you have to find out if they have goals and we figure out what their goals are and slowly work on that. (P5; No SU; Urban)

Participants also described identifying and trying substance-free activities with CSC clients, for example, attending local AA and NA groups, increasing time socializing with people who were not engaging in SU, and identifying and engaging in new hobbies.

Conclusions and Implications for Practice

This study describes a range of CSC peer specialist responses to client SU. Our findings speak to the complicated nature of understanding and responding to SU within the landscape of community mental health today—wherein SU training is lacking across the entire mental health workforce despite its high prevalence as a comorbidity (Center for Mental Health Services, 2019). Although this study focused on peer specialists, it is likely that the same challenges exist across CSC roles—due to the dearth of SU training and the lack of a specific integrated SU approach within CSC. Opportunity exists for developing SU practice theory and related training for the CSC workforce. This study uncovers several historical and philosophical tensions at play between clinical, SU recovery, and peer support approaches. These tensions deserve greater attention in CSC practice, policy, research, and workforce development.

Philosophical and Practice Tensions

A predominant underlying tension that emerged in this study was between clinical and peer support understandings and approaches to SU. During interviews, participants used a mix of both clinical (e.g., "assess, treat, diagnose, diagnosis, disorder") and more stigmatized terminology (e.g., "addiction, addict, alcoholic, in-recovery") to talk about SU. Some participants placed certain emphasis that the peer support lived experience perspective was of critical value in relation to more clinical or medical model understandings of SU, while others wanted more clinical knowledge and training on SU. Participants also varied in whether they perceived client SU as problematic or dangerous compared to developmentally normative experimentation. During data analysis, the research team repeatedly found themselves asking: What is substance "use" versus "misuse" versus "clinically disordered use" versus recreational or acceptable use?

Participants grappled with understanding client SU as being related to mental health (e.g., trauma, coping with distress, social anxiety) compared to being deviant, noncompliant, and "bad." In some instances, SU was described as a personal choice and seen as a poor choice if one has early psychosis—exacerbating symptoms or thwarting treatment (e.g., medication). Complicating matters is how mental health struggles are framed frequently as not one's fault or choice but possibly could be if early psychosis was initiated via SU. Some participants went as far as to disavow the notion that SU-related struggles were one's own "fault" or "bad" behavior and felt it was their duty to educate their team and clients about harmful SU messaging. These tensions map onto larger societal biases about SU as one's fault rather than self-medication for mental health. These tensions must be further explored to develop effective CSC SU practice that acknowledges history and stigma, and promotes equity in peer, clinical, and SU recovery perspectives.

Exploring SU and Matching SU Perspective

Participants emphasized the importance of a nonjudgmental, exploratory approach toward SU, which is reflected in the suggested CSC SU best practice (Bello & Dixon, 2022). Sharing personal SU experiences to educate about SU risks and warn clients about potential SU harm was common among participants. However, validating one's present struggles related to SU is different than warning about potential SU-related struggles. Even if well-intentioned (i.e., to educate and protect), "rock-bottom" stories can perpetuate a fear-based narrative toward SU, which ultimately leads to stigma and has thus far been ineffective at mitigating SU-related harm (Esrick et al., 2019). Respecting individuals' decisions around SU is critical in adult community mental health (Haskell et al., 2016). Learning how and when to share from personal SU experiences is an area of opportunity for CSC peer specialist training and supervision.

Determining when and how to bring up SU and educate about associated risks can be difficult, especially with cannabis, given its increasing legality, availability, the variety of compounds, and their different relationships with psychosis. CSC peer specialists possess varying beliefs, experience, and knowledge about SU that impact how they respond to client SU. All participants emphasized their desire to know more about SU and effective treatment approaches. One study suggested that professionals trained in SU treatment, for

example, certified SU and addiction specialists, could be incorporated into CSC teams (Oluwoye & Fraser, 2021). To date, research of teams with a recovery/SU specialist role has not been published, although qualitative work reveals that providers feel this would be a useful additional role (Stokes et al., 2022), and CSC teams in several states have SU specialist roles (Bello & Dixon, 2022).

Study Limitations

Study participant age, race, ethnicity, and gender were not collected to protect confidentiality. Only 20 peer specialists were interviewed, most from Texas, perhaps limiting generalizability to U.S. CSC peer specialists. However, data collection, analysis, and article writing included multiple perspectives, including those with lived experience with both SU and mental health treatment, as well as delivering peer support and clinical services. Future research of SU support from peer specialists and other CSC team members should include perspectives of CSC clients, families, and SU providers that teams refer clients to. Future work should systematically explore how all CSC team members respond to client SU and evaluate SU practice integration on CSC team collaboration and client outcomes.

Informing a Peer Support SU Intervention

In conjunction with a qualitative study of CSC client perspectives on their SU (Myers et al., 2023), these study results were translated into a practice approach called *Peer Approaches to Substances in Early Psychosis Programs*. Peer Approaches to Substances in Early Psychosis Programs promotes nonjudgmental exploration, matching lived/living SU (or related) experiences to validate individuals, explore SU risks together, employ harm reduction strategies, connect to substance-free community activities, and promote positive social network expansion. Each of these activities aligns with peer support values, practices, and core competencies (Foglesong et al., 2022; Substance Abuse and Mental Health Services Administration, 2018). The toolkit and associated training are promising for improving peer specialist confidence and competence in supporting clients to make informed decisions and develop and achieve SU-related goals.

Conclusion

This study details a spectrum of responses that CSC peer specialists employed to help CSC clients reflect on why they are using substances, risks associated with SU, and methods to change SU. As stigma around SU and related struggles shifts, and early interventions for psychosis increase, there is an expanding opportunity and need for CSC research to explore how peer specialists and entire CSC teams understand, educate, and address client SU. We hope such work can lead to an increased capacity to effectively mitigate SU-related harm among young people with first-episode psychosis.

References

Abdel-Baki, A., Ouellet-Plamondon, C., Salvat, É., Grar, K., & Potvin, S. (2017). Symptomatic and functional outcomes of substance use disorder persistence 2 years after admission to a first-episode psychosis program. *Psychiatry Research*, 247, 113–119. <https://doi.org/10.1016/j.psychres.2016.11.007>

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425787>

Anderson, K. K., Norman, R., MacDougall, A. G., Edwards, J., Palaniyappan, L., Lau, C., & Kurdyak, P. (2019). Estimating the incidence of first-episode psychosis using population-based health administrative data to inform early psychosis intervention services. *Psychological Medicine*, 49(12), 2091–2099. <https://doi.org/10.1017/S0033291718002933>

Bello, I., & Dixon, L. (2022). *Treating affective psychosis and substance use disorders within coordinated specialty care*. Technical Assistance Material Developed for SAMHSA/CMHS. https://www.nasmhpd.org/site/default/files/2022-03/DH-TreatingAffectivePsychosis_v2.pdf

Bennett, M., Lee, R., Watkins, L., Bellow, I., Deegan, P., DuBrul, S. A., Nossell, I., & Dixon, L. (2018). *OnTrackNY team manual*. <https://ontrackny.org/Portals/1/Files/Resources/Team%20Manual%207-2018%20Revision.pdf?ver=2018-08-03-125125-913>

Braun, V., & Clarke, V. (2023). Toward good practice in thematic analysis: Avoiding common problems and becoming a knowing researcher. *International Journal of Transgender Health*, 24(1), 1–6. <https://doi.org/10.1080/26895269.2022.2129597>

Cather, C., Brunette, M. F., Mueser, K. T., Babbitt, S. F., Rosenheck, R., Correll, C. U., & Kalos-Meyer, P. (2018). Impact of comprehensive treatment for first episode psychosis on substance use outcomes: A randomized controlled trial. *Psychiatry Research*, 268, 303–311. <https://doi.org/10.1016/j.psychres.2018.06.055>

Center for Mental Health Services. (2019). *Developing a behavioral health workforce equipped to serve individuals with co-occurring mental health and substance use disorders substance abuse and mental health services administration*. https://www.nasmhpd.org/sites/default/files/TAC_Paper_3_508C_0.pdf

Charlson, F. J., Ferrari, A. J., Santomauro, D. F., Diminic, S., Stockings, E., Scott, J. G., McGrath, J. J., & Whiteford, H. A. (2018). Global epidemiology and burden of schizophrenia: Findings from the global burden of disease study 2016. *Schizophrenia Bulletin*, 44(6), 1195–1203. <https://doi.org/10.1093/schbul/sby058>

Cohen, D. A., Klodnick, V. V., Reznik, S. J., & Lopez, M. A. (2023). Expanding early psychosis care across a large and diverse state: Implementation lessons learned from administrative data and clinical team leads in Texas. *Administration and Policy in Mental Health*, 50(6), 861–875. <https://doi.org/10.1007/s10488-023-01285-8>

Colizzi, M., Carra, E., Fraietta, S., Lally, J., Quattrone, D., Bonaccorso, S., Mondelli, V., Ajnakina, O., Dazzan, P., Trotta, A., Sideli, L., Kolliakou, A., Gaughran, F., Khondoker, M., David, A. S., Murray, R. M., MacCabe, J. H., & Di Forti, M. (2016). Substance use, medication adherence and outcome one year following a first episode of psychosis. *Schizophrenia Research*, 170(2–3), 311–317. <https://doi.org/10.1016/j.schres.2015.11.016>

Di Forti, M., Sallis, H., Allegri, F., Trotta, A., Ferraro, L., Stilo, S. A., Marconi, A., La Cascia, C., Reis Marques, T., Pariante, C., Dazzan, P., Mondelli, V., Paparelli, A., Kolliakou, A., Prata, D., Gaughran, F., David, A. S., Morgan, C., Stahl, D., ... Murray, R. M. (2014). Daily use, especially of high-potency cannabis, drives the earlier onset of psychosis in cannabis users. *Schizophrenia Bulletin*, 40(6), 1509–1517. <https://doi.org/10.1093/schbul/sbt181>

Dixon, L. B., Goldman, H. H., Bennett, M. E., Wang, Y., McNamara, K. A., Mendon, S. J., Goldstein, A. B., Choi, C. W., Lee, R. J., Lieberman, J. A., & Essock, S. M. (2015). Implementing coordinated specialty care for early psychosis: The RAISE Connection Program. *Psychiatric Services*, 66(7), 691–698. <https://doi.org/10.1176/appi.ps.201400281>

DuBrul, S. A., Deegan, P., Bello, I., Dean, E., Grossman, E., Chang, C., Watkins, L., Piscitelli, S., Lee, R., Ngo, H., Nossell, I., Vardin, A., & Dixon, L. (2017). *Peer specialist manual*. OnTrackNY. https://ontrackny.org/portals/1/Files/Resources/Peer%20Specialist%20Manual%20Final%202_17.17.pdf?ver=2017-04-04-063602-080

- Esrick, J., Kagan, R. G., Carnevale, J. T., Valenti, M., Rots, G., & Dash, K. (2019). Can scare tactics and fear-based messages help deter substance misuse: A systematic review of recent (2005–2017) research. *Drugs: Education Prevention & Policy*, 26(3), 209–218. <https://doi.org/10.1080/09687637.2018.1424115>
- Foglesong, D., Knowles, K., Cronise, R., Wolf, J., & Edwards, J. P. (2022). National practice guidelines for peer support specialists and supervisors. *Psychiatric Services*, 73(2), 215–218. <https://doi.org/10.1176/appi.ps.202000901>
- Fraser, E. R., Kordas, G., Stokes, B., McDonell, M. G., & Oluwoye, O. (2023). Recent substance use among clients with early psychosis and the potential to graduate from New Journeys. *Early Intervention in Psychiatry*, 17(6), 636–640. <https://doi.org/10.1111/eip.13386>
- Hasan, A., von Keller, R., Friemel, C. M., Hall, W., Schneider, M., Koethe, D., Leweke, F. M., Strube, W., & Hoch, E. (2020). Cannabis use and psychosis: A review of reviews. *European Archives of Psychiatry and Clinical Neuroscience*, 270(4), 403–412. <https://doi.org/10.1007/s00406-019-01068-z>
- Haskell, R., Graham, K., Bernards, S., Flynn, A., & Wells, S. (2016). Service user and family member perspectives on services for mental health, substance use/addiction, and violence: A qualitative study of their goals, experiences and recommendations. *International Journal of Mental Health Systems*, 10(1), Article 9. <https://doi.org/10.1186/s13033-016-0040-3>
- Heinssen, R. K., & Azrin, S. T. (2022). A national learning health experiment in early psychosis research and care. *Psychiatric Services*, 73(9), 962–964. <https://doi.org/10.1176/appi.ps.20220153>
- Heinssen, R. K., Goldstein, A. B., & Azrin, S. T. (2014). *Evidence-Based treatments for first episode psychosis: Components of coordinated specialty care* [RAISE: Recovery after an Initial Schizophrenia Episode]. National Institute of Mental Health. https://www.nasmhpd.org/sites/default/files/Summary%20of%20Evidence-BasedTreatment%20Components%20for%20FEP_14APR_2014_Final.pdf
- Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), 593–602. <https://doi.org/10.1001/archpsyc.62.6.593>
- Lange, E. H., Nesvåg, R., Ringen, P. A., Hartberg, C. B., Haukvik, U. K., Andreassen, O. A., Melle, I., & Agartz, I. (2014). One year follow-up of alcohol and illicit substance use in first-episode psychosis: Does gender matter? *Comprehensive Psychiatry*, 55(2), 274–282. <https://doi.org/10.1016/j.comppsy.2013.08.018>
- Large, M., Sharma, S., Compton, M. T., Slade, T., & Nielssen, O. (2011). Cannabis use and earlier onset of psychosis: A systematic meta-analysis. *Archives of General Psychiatry*, 68(6), 555–561. <https://doi.org/10.1001/archgenpsychiatry.2011.5>
- Leeson, V. C., Harrison, I., Ron, M. A., Barnes, T. R., & Joyce, E. M. (2012). The effect of cannabis use and cognitive reserve on age at onset and psychosis outcomes in first-episode schizophrenia. *Schizophrenia Bulletin*, 38(4), 873–880. <https://doi.org/10.1093/schbul/sbq153>
- Marconi, A., Di Forti, M., Lewis, C. M., Murray, R. M., & Vassos, E. (2016). Meta-analysis of the association between the level of cannabis use and risk of psychosis. *Schizophrenia Bulletin*, 42(5), 1262–1269. <https://doi.org/10.1093/schbul/sbw003>
- Marino, L., Scodes, J., Richkin, T., Alves-Bradford, J. M., Nossel, I., Wall, M., & Dixon, L. (2020). Persistent cannabis use among young adults with early psychosis receiving coordinated specialty care in the United States. *Schizophrenia Research*, 222, 274–282. <https://doi.org/10.1016/j.schres.2020.05.035>
- Mueser, K. T., Noordsy, D. L., Drake, R. E., & Fox, L. (2003). *Integrated treatment for dual disorders: A guide to effective practice* (D. H. Barlow, Ed.). Guilford Press. <https://doi.org/10.1093/alcac/agh147>
- Mueser, K. T., Penn, D. L., Addington, J., Brunette, M. F., Gingerich, S., Glynn, S. M., Lynde, D. W., Gottlieb, J. D., Meyer-Kalos, P., McGurk, S. R., Cather, C., Saade, S., Robinson, D. G., Schooler, N. R., Rosenheck, R. A., & Kane, J. M. (2015). The NAVIGATE program for first-episode psychosis: Rationale, overview, and description of psychosocial components. *Psychiatric Services*, 66(7), 680–690. <https://doi.org/10.1176/appi.ps.201400413>
- Myers, N. L., Wilkey, J., Chacon, M., Hutnyan, M., Janssen, C., Tarvin, H., Cohen, D., Holmes, I., Klodnick, V. V., Mihiret, M. A., Reznik, S. J., Shimizu, T. K., Stein, E., & Lopez, M. A. (2023, November). Perspectives of young adults diagnosed with early psychosis using coordinated specialty care in Texas on substance use and substance use interventions. *Early Intervention in Psychiatry*. Advance online publication. <https://doi.org/10.1111/eip.13488>
- Myles, H., Myles, N., & Large, M. (2016). Cannabis use in first episode psychosis: Meta-analysis of prevalence, and the time course of initiation and continued use. *Australian and New Zealand Journal of Psychiatry*, 50(3), 208–219. <https://doi.org/10.1177/0004867415599846>
- National Association for Alcoholism and Drug Abuse Counselors. (2023). *National Certified Peer Recovery Support Specialist (NCPRSS) code of ethics*. <https://www.naadac.org/ncprss-code-of-ethics>
- Oluwoye, O., & Fraser, E. (2021). Barriers and facilitators that influence providers' ability to educate, monitor, and treat substance use in first-episode psychosis programs using the theoretical domains framework. *Qualitative Health Research*, 31(6), 1144–1154. <https://doi.org/10.1177/1049732321993443>
- Oluwoye, O., Monroe-DeVita, M., Burduli, E., Chwastiak, L., McPherson, S., McClellan, J. M., & McDonell, M. G. (2019). Impact of tobacco, alcohol and cannabis use on treatment outcomes among patients experiencing first episode psychosis: Data from the national RAISE-ETP study. *Early Intervention in Psychiatry*, 13(1), 142–146. <https://doi.org/10.1111/eip.12542>
- Oscós-Sánchez, M. Á., Lesser, J., Oscós-Flores, L. D., Pineda, D., Araujo, Y., Franklin, B., Hernández, J. A., Hernández, S., & Vidales, A. (2021). The effects of two community-based participatory action research programs on violence outside of and in school among adolescents and young adults in a Latino community. *Journal of Adolescent Health*, 68(2), 370–377. <https://doi.org/10.1016/j.jadohealth.2020.10.004>
- Ouellet-Plamondon, C., Abdel-Baki, A., Salvat, É., & Potvin, S. (2017). Specific impact of stimulant, alcohol and cannabis use disorders on first-episode psychosis: 2-year functional and symptomatic outcomes. *Psychological Medicine*, 47(14), 2461–2471. <https://doi.org/10.1017/S0033291717000976>
- Patel, R., Wilson, R., Jackson, R., Ball, M., Shetty, H., Broadbent, M., Stewart, R., McGuire, P., & Bhattacharyya, S. (2016). Association of cannabis use with hospital admission and antipsychotic treatment failure in first episode psychosis: An observational study. *BMJ Open*, 6(3), Article e009888. <https://doi.org/10.1136/bmjopen-2015-009888>
- Peer Recovery Center of Excellence. (2023). *State certification database*. Substance Abuse and Mental Health Services Administration. <https://peerrecoverynow.org/resource-library/state-certification-database/>
- Penn, D. L., Meyer-Kalos, P. S., & Gottlieb, J. D. (2020). *NAVIGATE individual resiliency training manual*. NAVIGATE Consulting. https://navigateconsultants.org/2020manuals/irt_2020.pdf
- Powell, A. L., Hinger, C., Marshall-Lee, E. D., Miller-Roberts, T., & Phillips, K. (2021). Implementing coordinated specialty care for first episode psychosis: A review of barriers and solutions. *Community Mental Health Journal*, 57(2), 268–276. <https://doi.org/10.1007/s10597-020-00644-1>
- Rosenheck, R., Mueser, K. T., Sint, K., Lin, H., Lynde, D. W., Glynn, S. M., Robinson, D. G., Schooler, N. R., Marcy, P., Mohamed, S., & Kane, J. M. (2017). Supported employment and education in comprehensive, integrated care for first episode psychosis: Effects on work, school, and disability

- income. *Schizophrenia Research*, 182, 120–128. <https://doi.org/10.1016/j.schres.2016.09.024>
- Schoeler, T., Monk, A., Sami, M. B., Klamerus, E., Foglia, E., Brown, R., Camuri, G., Altamura, A. C., Murray, R., & Bhattacharyya, S. (2016). Continued versus discontinued cannabis use in patients with psychosis: A systematic review and meta-analysis. *The Lancet Psychiatry*, 3(3), 215–225. [https://doi.org/10.1016/S2215-0366\(15\)00363-6](https://doi.org/10.1016/S2215-0366(15)00363-6)
- Schoeler, T., Petros, N., Di Forti, M., Klamerus, E., Foglia, E., Murray, R., & Bhattacharyya, S. (2017). Poor medication adherence and risk of relapse associated with continued cannabis use in patients with first-episode psychosis: A prospective analysis. *The Lancet Psychiatry*, 4(8), 627–633. [https://doi.org/10.1016/S2215-0366\(17\)30233-X](https://doi.org/10.1016/S2215-0366(17)30233-X)
- Shalaby, R. A. H., & Agyapong, V. I. O. (2020). Peer support in mental health: Literature review. *JMIR Mental Health*, 7(6), Article e15572. <https://doi.org/10.2196/15572>
- Stokes, B., Fraser, E., Kriegel, L., & Oluwoye, O. (2022). Exploring provider perspectives on implementing coordinated specialty care: A qualitative study. *Community Mental Health Journal*, 58(7), 1321–1328. <https://doi.org/10.1007/s10597-022-00939-5>
- Substance Abuse and Mental Health Services Administration. (2018). *Core Competencies for Peer Workers in Behavioral Health Services* [Bringing Recovery Supports to Scale, Technical Assistance Center Strategy]. https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/core-competencies_508_12_13_18.pdf
- Substance Abuse and Mental Health Services Administration. (2019). *First-episode psychosis and co-occurring substance use disorders*. Substance Use Policy Laboratory. https://store.samhsa.gov/sites/default/files/d7/pri-v/pep19-pl-guide-3_0.pdf
- Velthorst, E., Fett, A. J., Reichenberg, A., Perlman, G., van Os, J., Bromet, E. J., & Kotov, R. (2017). The 20-year longitudinal trajectories of social functioning in individuals with psychotic disorders. *The American Journal of Psychiatry*, 174(11), 1075–1085. <https://doi.org/10.1176/appi.ajp.2016.15111419>
- Walker, M., Carpino, M., Lightfoot, D., Rossi, E., Tang, M., Mann, R., Saarela, O., & Cusimano, M. D. (2023). The effect of recreational cannabis legalization and commercialization on substance use, mental health, and injury: A systematic review. *Public Health*, 221, 87–96. <https://doi.org/10.1016/j.puhe.2023.06.012>
- Weibell, M. A., Hegelstad, W. T. V., Auestad, B., Bramness, J., Evensen, J., Haahr, U., Joa, I., Johannessen, J. O., Larsen, T. K., Melle, I., Opjordsmoen, S., Rund, B. R., Simonsen, E., Vaglum, P., McGlashan, T., McGorry, P., & Friis, S. (2017). The effect of substance use on 10-year outcome in first-episode psychosis. *Schizophrenia Bulletin*, 43(4), 843–851. <https://doi.org/10.1093/schbul/sbw179>
- White, W. L. (2014). *Slaying the dragon: The history of addiction treatment and recovery in America*. Chestnut Health Systems.

Received October 11, 2023

Revision received February 6, 2024

Accepted February 8, 2024 ■