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CONTROL POLICY



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RECOVERY

National Summit on Recovery From Substance Use Disorders

*Bringing Together the Head
and the Heart of Recovery*

Washington, DC
September 14, 2010



September 14, 2010

Dear Reader:

We are pleased to present the proceedings of the *National Summit on Recovery From Substance Use Disorders: Bringing Together the Head and the Heart of Recovery*, which the Substance Abuse and Mental Health Services Administration (SAMHSA) and the White House Office of National Drug Control Policy (ONDCP) jointly convened in September 2010.

This Summit followed a groundbreaking 2005 National Summit on Recovery convened by SAMHSA. The two overarching goals of the 2010 proceedings were to take stock of what has been accomplished since 2005 and to identify critical steps that still need to be taken to achieve the vision of Recovery-Oriented Systems of Care (ROSC) in the contexts of a health care landscape that will be significantly changed by the full implementation of the Patient Protection and Affordable Care Act (PPACA). Building on work initiated during an August 2010 summit convened by SAMHSA, participants were also asked to consider what it would take to develop a broader vision of recovery that includes both substance use and mental health problems, that builds on the commonalities between the two, while respecting their differences in recovery process, goals, needs, and cultures.

Summit participants were asked to tackle this ambitious and multi-faceted agenda in a single day. That so much was accomplished in such a short period of time is a credit to the dedication and creativity of participants, SAMHSA and ONDCP staff, and others who planned and skillfully facilitated the Summit. Participants proposed the development of a National Recovery Agenda and recommended actions to support it in areas such as collaboration and coordination, standards, measures and outcomes, innovative practices, social inclusion, and training and education. Their accomplishments are emblematic of the value that can emerge from collaboration informed by common values, compatible visions of the future, respect for differences, and a shared sense of urgency.

As addictions and mental health systems begin to be transformed in anticipation of integration with broader health systems, and as efforts are made to develop the workforce capacities needed to become part of mainstream health care, we are faced with significant challenges and great opportunities. Collaboration of the kind so well-modeled by Summit participants will be essential if we are to successfully integrate into 21st century health systems.

It was a privilege to take part in this important meeting. We look forward to continuing these critically important efforts to develop a shared vision and collaborative solutions to the many challenges facing the addictions and mental health fields as they move toward a richer partnership and become more fully integrated with our Nation's health care infrastructure.

Sincerely,

David K. Mineta
Deputy Director
Office of Demand Reduction
Office of National Drug Control Policy

Pamela S. Hyde, JD
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Substance Abuse and Mental Health Services
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This report summarizes the proceedings of the 2010 National Summit on Recovery From Substance Use Disorders, held in Washington, DC, on September 14, 2010. The Substance Abuse and Mental Health Services Administration (SAMHSA) and the Office of National Drug Control Policy (ONDCP) planned the summit.

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Disclaimer

The views and opinions expressed herein are those of the participants at the 2010 National Summit on Recovery From Substance Use Disorders and do not necessarily reflect the views, opinions, or official policy of the Substance Abuse and Mental Health Services Administration or the Office of National Drug Control Policy.

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PART I: OVERVIEW

Background

The National Summit on Recovery From Substance Use Disorders was held on September 14, 2010, in Washington, DC and built on a foundation established 5 years earlier during the National Summit on Addiction Recovery. In 2005, the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Substance Abuse Treatment (CSAT), brought leaders from the substance use disorders (SUDs) treatment and recovery field to Washington, DC, for the first National Summit on Recovery. That earlier summit spurred national efforts to create recovery-oriented systems and services in the SUDs treatment and recovery field. Its three goals were:

1. Develop new ideas to transform policy, services, and systems toward a recovery-oriented paradigm that would be more responsive to the needs of people in or seeking recovery from substance use disorders, as well as to their families and significant others.
2. Articulate guiding principles and measures of addiction recovery that could be used across programs and services to promote and capture improvements in systems of care, facilitate data sharing, and enhance program coordination.
3. Generate ideas for advancing recovery-oriented systems of care (ROSC) in various settings and systems (e.g., criminal justice, faith communities, peer support programs) and for specific populations (e.g., racial, ethnic, and cultural groups; women; people in medication-assisted recovery; people with co-occurring disorders).

As a result of the 2005 Summit, components of a ROSC framework were established. These components included a working definition of recovery, guiding principles of recovery, and elements of a ROSC. The 2005 Summit and the work of the pioneers who initiated efforts toward recovery-oriented systems and services established a foundation for transformational systems and services in support of recovery across the country.

In the year prior to SAMHSA's Addiction Recovery Summit, a conference was held in 2004 among mental health consumers, family members, providers, advocates, researchers, and others, to develop the National Consensus Statement on Mental Health Recovery. Over 110 experts participated in the development of the consensus statement and 10 fundamental components of mental health recovery.

The progress made over the years since the previous recovery events has created an environment where a broader national recovery agenda is emerging.

This agenda extends beyond the SUDs treatment and recovery field and engages partners from multiple Federal, State, and local agencies. SAMHSA and the Office of National Drug Control Policy (ONDCP) took a step toward this goal by co-hosting the National Summit on Recovery From Substance Use Disorders in 2010.

The 2010 Summit was designed to assess the progress made since SAMHSA's earlier recovery events, and to determine the critical work that remains to be done to advance a recovery agenda. With the passage of the Affordable Care Act (ACA), the 2010 Summit also set out to plan for the ongoing development of ROSC within the context of systems and services that are more fully integrated with broader health systems. The ACA presents an opportunity to design health systems that promote and further support resiliency and recovery.

National Summit on Recovery 2010 – At a Glance

The National Summit on Recovery From Substance Use Disorders was held in Washington, DC, on September 14, 2010. This notable event solidified a commitment to integrate recovery principles across multiple Federal, State, and local systems. The 2010 Summit's 1-day agenda challenged participants to accomplish considerable work within a compressed timeframe.

The event began with a framing of the Summit's issues and objectives by a panel of Federal officials from ONDCP, SAMHSA, and the Department of Education. A second panel, consisting of leaders in the recovery movement, discussed the changes that had occurred since the 2005 National Summit on Addiction Recovery and the 2004 National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation. The presenters recognized significant public events, the passage of legislation supporting facets of recovery, health care reform, and the systems transformations currently under way. The panel also cited issues that still remain, and challenged Summit participants to tackle them during the afternoon breakout sessions.

The final presentation of the morning highlighted the background, intent, and main provisions of the ACA, including the rationale for its passage, the benefits, the timetable, and specific features related to prevention, primary care, and long-term care.

A luncheon speaker further engaged the participants through an inspirational message and personal reflections of recovery. Energized by the luncheon speaker and armed with insights from the Federal and expert panelists, the Summit participants embarked upon a work assignment. They were asked to select one of 10 topical breakout sessions, where they were instructed to identify issues primary to their topical area; determine successful strategies and approaches; identify related challenges and barriers and the level of involvement of Federal,

State, and local officials with these issues; describe recovery principles embedded in practices and processes to address those issues; and determine steps to move the agenda forward.

After the breakout groups, the participants reconvened as a whole, and shared highlights from each breakout session. Summit participants identified a number of common themes and issues that warranted further review and discussion.

The day ended with closing remarks from ONDCP's Deputy Director of Demand Reduction.

Summit Participants

More than 150 Summit participants from 35 States assembled, creating an energized environment for discussion and the exchange of ideas on recovery, resilience, and wellness for people with substance use and mental disorders. Participants represented change leaders from the addiction and mental health fields, including those in addiction recovery, mental health consumers, family members, policymakers, and providers. The majority of Summit participants identified themselves as people in recovery. To build on earlier efforts, a number of SAMHSA's and ONDCP's Federal partners as well as representatives of national organizations participated in this Summit. Attendees brought a wide range of expertise on matters related to recovery. The Departments of Labor, Education (ED), Health and Human Services, Justice, and Housing and Urban Development participated in the Summit.

Summit Highlights

The following information provides a brief summary of the themes that emerged from the 2010 National Summit on Recovery From Substance Use Disorders. Additional detail and information concerning the Summit can be found later in this document.

The 2010 National Summit on Recovery From Substance Use Disorders brought together "the head and the heart of recovery." Following the contextual remarks provided by leaders from ONDCP, SAMHSA, ED, and experts in the behavioral health field, several themes emerged from the Summit participants' dialogue.

The overarching theme from the Summit was a call for a **National Recovery Agenda**. A national agenda will serve to unify policies and issues among Federal, State, and local agencies in support of recovery. Through the agenda, policy barriers can be reduced, social inclusion promoted, resources and collaborations defined, and accountability measures established. To advance the agenda, needed actions were identified in the following areas:

- Collaboration and Coordination: Consistent messaging related to promoting recovery and addressing social policy barriers is needed among Federal, State, and local partners. Additional public and private partnerships need to be defined and established.
- Standards: Standards of practice should be established, beginning with the use of common language across systems. A credentialing mechanism for peer support service providers is needed to delineate and sustain their vital role.
- Measures and Outcomes: A recovery measure should be established, and data systematically collected and analyzed from multiple health and human agencies to determine recovery outcomes.
- Innovative Practices: Evidence-based and promising practices that support recovery should be promoted. Further, the research community (e.g., the National Institute on Drug Abuse [NIDA], the National Institute on Alcohol Abuse and Alcoholism [NIAAA], and the National Institute of Mental Health [NIMH]) should be engaged to discuss future research efforts related to recovery.
- Social Inclusion: An informed and supportive public perception of those in addiction and mental health recovery needs to be created. Negative terminology used to describe persons with SUDs or a mental disorder should be replaced with descriptions that communicate “wellness.”
- Training and Education: Federal, State, and local organizations should receive training on recovery principles. Cross-training and skill building are needed to promote recovery within the behavioral health field and in numerous health and human service agencies that play a role in supporting recovery.

By devoting attention to the categories articulated above in a National Recovery Agenda, significant strides will be made to further recovery at the Federal, State, and local levels. To further augment the agenda, next steps encompassing specific populations, services, supports, and communities were identified.

PART II: SETTING THE STAGE – FEDERAL LEADERS FRAME THE ISSUES

Key Federal officials set the tone for the Summit by discussing issues related to recovery in the context of today’s new health care environment, and by linking the issues to the objectives of the Summit. A summary of their remarks follows.

Welcome and Introduction: Dr. H. Westley Clark, Director, Center for Substance Abuse Treatment



On behalf of the Substance Abuse and Mental Health Services Administration and as a joint sponsor of the National Summit on Recovery From Substance Use Disorders, Dr. Clark welcomed participants. He stated that the Summit agenda was designed to elicit input from leaders in the behavioral health care system about what is happening around the country to promote recovery, and to share important information on the status of health care reform. He further said that our collective understanding of recovery has evolved since the 2004 National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation and the 2005 National Summit on Addiction Recovery. The field has moved from conceptualizing the ROSC framework to adopting and implementing it. Dr. Clark then proceeded to introduce the objectives of the 2010 Summit:

- To update recovery stakeholders on national health reform and system change initiatives.
- To gather information from stakeholders about the current state of recovery-oriented initiatives in the field and in the community.
- To initiate dialogue on recovery-supportive policies, and on strategies that facilitate the integration of behavioral health and primary care.
- To advance recovery-oriented strategies within other systems, to better serve and support individuals and families who are in or are seeking long-term recovery.

Following a review of the Summit objectives, Dr. Clark introduced R. Gil Kerlikowske, Director of the White House Office of National Drug Control Policy.

Recovery and the National Drug Control Strategy: R. Gil Kerlikowske, Director, Office of National Drug Control Policy



Director Kerlikowske discussed the National Drug Control Strategy, highlighting its emphasis on prevention and treatment and on providing comprehensive services that support recovery. He noted that the Summit provides an important opportunity for ONDCP, SAMHSA, and the Department of Education to support recovery-related efforts. He noted that President Obama had communicated a vision of creating positive change by leveraging resources and collaboration. This Summit, Mr. Kerlikowske said, is an example of that vision. Director Kerlikowske explained that the National Drug Control Strategy recognizes that addiction should be treated in the same manner as other chronic illnesses, and that supports should be in place to facilitate individuals' lifelong management of their recovery processes. The Director spoke of the vital role that community leaders play in spreading the word that treatment results in savings and promotes safe and healthy communities. Director Kerlikowske emphasized that "we can't arrest our way out of this problem; we have to direct our attention to prevention." He encouraged collaborations with police chiefs, prosecutors, and other law enforcement officials to carry the message of recovery and to leverage resources that support prevention, treatment, and recovery services. He thanked everyone for sharing their ideas on roadblocks to recovery, and on strategies for successfully supporting long-term recovery.

"We can't arrest our way out of this problem; we have to direct our attention to prevention."

Director Kerlikowske

Defining, Supporting, and Measuring Recovery: Pamela Hyde, Administrator, Substance Abuse and Mental Health Services Administration



Administrator Hyde outlined SAMHSA's commitment to recovery, stating that "recovery is not about services and systems; it is about improving people's lives." She noted that people must not be reduced to a set of symptoms that are treated. Policies, regulations, programs, and budgets must always place people first. Administrator Hyde said that this approach is echoed in SAMHSA's four main messages.

- **Behavioral health is essential to health.** Behavioral health is an integral part of general health and is reflected in the tenets of health care reform.
- **Prevention works.** By promoting protective factors, particularly for children, we can strengthen emotional health.

“Recovery is not about services and systems; it is about improving people’s lives.”

Pamela Hyde

- **Treatment is effective.** Treatment is necessary for many individuals who suffer from SUDs.
- **People recover.**

Administrator Hyde described how an individual’s choices, dreams, and self-determination drive recovery. She described recovery as individualized and holistic, and as best supported through integrated and comprehensive services. She pointed out that there are many paths to recovery, and that it can be enhanced through social inclusion, community support, and peer facilitation. Administrator Hyde concluded her remarks by identifying two important challenges the field must accept: (1) framing recovery so it can be measured (e.g., are individuals living healthy lives; do they have a home, a purpose, and the resources they need?), and (2) asking how to accomplish a commitment to recovery in the context of health care reform.

Recovery in the Context of Education: Kevin Jennings, Assistant Deputy Secretary of Education, Office of Safe and Drug-Free Schools



Assistant Deputy Secretary Jennings shared two messages with the Summit participants. First, he stated that he views people who have achieved recovery as heroes. He noted his admiration not only for their professional accomplishments, but also for their “inner résumé of accomplishment,” or those things that keep them strong and healthy. His second message was that recovery is an education issue. Students cannot do well

in school if they are experiencing problems with alcohol and drugs. Research provides evidence that alcohol and drug use have a considerable negative impact on grades as well as on overall academic achievement. Yet there is significant denial within the educational system regarding the extent of alcohol and drug problems among students. Strategies are needed to help children avoid using drugs in the first place. Additionally, students who have developed drug problems require assistance accessing treatment services and support within the academic environment to achieve and maintain recovery.

PART III: WHAT HAS CHANGED SINCE THE PREVIOUS RECOVERY EVENTS?

A panel of experts reflected upon the many changes that have taken place since SAMHSA's 2005 National Summit on Addiction Recovery and the 2004 consensus conference and the likely impact on the future. The panel was introduced and moderated by Ivette A. Torres, Associate Director of Consumer Affairs, for the SAMHSA Center for Substance Abuse Treatment.



The Current State of Affairs – Progress & Work to be Done: Tom Hill, Director of Programs, Faces and Voices of Recovery

A number of milestones in the expanding recovery movement were shared by Mr. Hill, including the 1998 launch of National Alcohol and Drug Addiction Recovery Month, the concurrent creation of the Recovery Community Support (subsequently Services) Program, and various recovery summits and symposiums that had taken place. He noted that the recovery movement continues to grow, mature, and better organize itself. He emphasized that there is a great deal to celebrate about how far the movement had come, but that there was still much more to be accomplished. Mr. Hill noted that significant work still needed to occur in the areas of educating the public and policymakers on the need for services and supports. He pointed out that history suggests that peer services are effective and should be funded. Peer recovery coaches and Recovery Community Centers are increasingly being seen as important to sustaining recovery. However, they require more

support. Mr. Hill said that the recovery community can and should advocate for that support.

Mr. Hill noted that the organized recovery community had been instrumental in advocating for important policy changes, including

- the 2006 partial repeal of the ban on Federal financial aid to students having a prior drug conviction,
- the 2007 Second Chance Act,
- the 2008 Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, and
- the 2010 inclusion of addiction and mental health treatment coverage within national health care reform legislation.

The new recovery focus, he explained, looks beyond recovery-oriented treatment, targeting development of recovery-oriented systems, to initiate, sustain, and honor long-term recovery. Mr. Hill pointed out that a number of SAMHSA/CSAT programs support this new, broader recovery focus, including the Access to Recovery, Recovery Community Services (RCSP), and ROSC Treatment Capacity Expansion grant programs. He also stated the new ONDCP recovery branch would lend additional support.

Mr. Hill noted that there are, however, ongoing challenges, including the need to

- reframe addiction recovery as a public health issue rather than a criminal justice matter;
- eradicate discriminatory practices in employment, housing, and other public sectors;
- educate the public that recovery is real, and create access to rights and benefits;
- build capacity for a nationwide network of sustainable recovery community organizations and Recovery Community Centers; and
- promote research concerning the recovery experience and development of evidence-based practices for peer recovery support services.

Mr. Hill concluded his remarks by offering a vision for the future. States, counties, and municipalities across the nation would support systems based on a recovery orientation. The organized recovery community organizations would serve as visible change agents—educating policymakers, forming networks and alliances, and responding to community challenges with tools of prevention, wellness, and recovery. Discriminatory policies against people in or seeking recovery would be eliminated, and people in recovery would be afforded the same rights and opportunities as people with other health conditions.

Recovery in the Mental Health Arena: Larry Fricks, Director, Appalachian Consulting Group; and Vice President of Peer Services, Depression and Bipolar Support Alliance

“The greatest potential for recovery and resiliency is not in the system but within each individual.”

Larry Fricks

Mr. Fricks discussed the fact that before 1980, the dominant view in the mental health system was that people with serious mental illness could not recover. The expectation was that individuals should be stabilized and maintained in supervised environments. Mr. Fricks noted that the 2003 report from the President’s New Freedom Commission on Mental Health opened with this statement: “We envision a future when everyone with a mental illness will recover” (*Achieving the Promise: Transforming Mental Health Care in America, Executive Summary*, Publication Number SMA03-3831 [Rockville, MD: The President’s New Freedom Commission on Mental Health, 2003], p. 1). The report acknowledged that the mental health system at that time was not focused on recovery, and it called for system transformation. In 2006, the National Association of State Mental Health Program Directors released the report *Morbidity and Mortality in People with Serious Mental Illness* (Alexandria, VA: National Association of State Mental Health Program Directors, 2006). This report revealed that people served in the public mental health system die, on average, 25 years earlier than the general population. This information, he explained, encouraged a shift to whole health and resiliency for people in recovery from mental illness and addiction.

Mr. Fricks then discussed passages from Rosalynn Carter’s book, *Within Our Reach: Ending the Mental Health Crisis* (Emmaus, PA: Rodale Books, 2010), which portrays stigma as the most damaging factor in the life of a person with mental illness. Stigma leads to discrimination and results in fear and rejection. However, Mr. Fricks pointed out that the book also envisioned a future in which recovery would be the expectation, opening doors to policy changes and expanded resources. He then noted that peer support services and a workforce of trained peers are significant resources. They use their lived experience of recovery and skills gained through training to help other peers focus on strengths and natural supports to direct their own recovery. A peer workforce also demonstrates competencies to change beliefs about stigma by role modeling recovery.

Mr. Fricks ended his remarks by stating that “promoting whole health recovery is a key to offsetting premature death and disability.” Whole health recovery is promoted through a strength-based system that encourages attention to mind-body factors and includes service to others and social networks to support recovery from both mental illness and addiction.

Meeting the Challenges of Systems Change to Support Recovery: Dr. Arthur Evans, Commissioner, Philadelphia Department of Behavioral Health and Intellectual disAbility Services

Dr. Evans began his comments by discussing how several of the national health care reform principles are consistent with a ROSC. This alignment has positioned the behavioral health care system to be competitive and relevant in the rapidly changing health care environment. Behavioral health care systems have increased the effectiveness and quality of care through treatment accessibility, person-directed care, professionalized mental health and addiction treatment, systems development for early intervention, and adoption of evidence-based practices. While these achievements have saved countless lives and contributed to the overall health of the population, the behavioral health field still faces challenges. These challenges include addressing unmet need for treatment services; low initiation and retention rates; significant health disparities based on race, geography, gender, and other factors; and a lack of continuity of care.

Dr. Evans identified three approaches that systems have used for ROSC transformation:

- **Additive:** This approach layers or adds new services (e.g., peer services) onto an existing system without making any changes to how the system operates. Issues within the system that may be at odds with recovery-oriented care are not addressed because the focus is on simply adding recovery support services.
- **Selective:** Practice and administrative changes are executed in selected parts of the system when adopting this approach. There is recognition that there are aspects of the current system that must change, as well as new recovery-oriented services being added, but interventions are limited to a select number of areas.
- **Transformational:** Culture and values drive practice, policy, and funding decisions in all parts and at all levels of the system when using this approach. Recovery-oriented care becomes the lens through which everything else is viewed. Every aspect of the system is evaluated in light of recovery principles, and a comprehensive approach is employed to align all elements to these principles.

Dr. Evans then discussed the essential elements of a transformational system or ROSC. Some of the key concepts mentioned were:

- The voice of persons in recovery is fundamental.
- Evidence-based practices and data-driven decision-making are critical.
- Prevention and early intervention are key components.
- Strategies include reducing the harm caused by addiction.
- Focus is placed on reducing known disparities related to race, ethnicity, gender, and sexual orientation.
- Emphasis is placed on addressing known clinical impediments to recovery, such as trauma and co-occurring conditions.

Dr. Evans concluded that the behavioral health field “must work diligently to ensure that the existing opportunities brought about by health care reform become a reality, and that we influence rather than merely follow.” He suggested several key actions in moving forward:

- **Medical necessity:** Remove barriers that prohibit the provision of the appropriate-level type and length of treatment because of overly restrictive medical necessity criteria.
- **Recovery research:** Integrate recovery-oriented services and supports into a developing research agenda.
- **Recovery performance measures:** Ensure that recovery-oriented performance measures are included as indicators of service quality.
- **Recovery as a philosophy:** Maintain and expand the recovery emphasis in the behavioral health field.
- **ROSC framework:** Continue to expand the ROSC conceptualization to include prevention, early intervention, and community health.
- **Integrate behavioral health and primary care:** Ensure integration between behavioral health care and primary care, but retain behavioral health care as a specialty.

Following the panelists’ presentations, the audience was invited to pose questions and comments. Details from the question-and-answer session can be found in Appendix B.

PART IV: A DIALOGUE ON THE IMPLICATIONS OF HEALTH CARE REFORM

An Overview of the Affordable Care Act (ACA): John O'Brien, Senior Advisor for Health Finance, SAMHSA



Summit participants were briefed by Mr. O'Brien on the status and benefits of the Affordable Care Act, major drivers of the act, implementation issues, and related challenges for the behavioral health care system. With regard to the status and benefits of the ACA, 30 regulations have been enacted. Federal Medicaid matching funds are now available to the States to cover additional low-income individuals and families. States will also be eligible to receive a higher matching percentage of Medicaid funds in 2014 for individuals at or below 133% of the Federal Poverty Level. Additionally, 1 million Medicare recipients are receiving "donut hole" checks to cover gaps in their prescription drug costs, and \$500 million has been authorized for the Prevention and Public Health Trust Fund in 2010. Mr. O'Brien then discussed a series of changes attributed to the ACA, which took effect on September 30, 2010. These changes

- extend coverage for young adults,
- provide free preventive care,
- allow appeals of coverage determinations,
- lift the lifetime limits on benefits, and
- prohibit (for children) exclusions from insurance coverage due to pre-existing conditions (adults will be included in 2014).

Several factors drove the composition of the final version of the ACA. These factors include the intent to

- provide health care coverage to additional individuals,
- expand the use of Medicaid to cover services for mental health and SUDs,
- focus on primary care and coordinate with specialty care,
- emphasize home- and community-based services and reduce reliance on institutional care, and
- emphasize preventing diseases and promoting wellness.

Mr. O'Brien proceeded to discuss the initial challenges in implementing health care reform, which began with the enrollment of newly covered individuals. By 2014, 32 million persons will be eligible for coverage. This large volume of enrollees, many of whom will be eligible for the first time, may be reluctant to enroll. Barriers to application may arise, individuals may move on and off eligibility rolls, and it may be challenging to track the enrollment process. Based on the experience of States that have implemented health care reform, attention will have to be paid to the enrollment process.

Additionally, the ACA allows a significant portion of services to be financed under Medicaid. The Medicaid program is responsible for ensuring mental health and addictions parity for persons enrolled in Medicaid managed care plans. Both a challenge and an opportunity is that the Medicaid program does not have extensive experience funding SUDs services. Significant work will be needed to enhance State and Federal partnerships to ensure appropriate coverage of SUDs.

Mr. O'Brien then discussed the importance of integrating primary care and behavioral health services to improve the quality and effectiveness of care. To illustrate the need for integration, he provided statistics on substance use and mental health disorders and the implications for primary care. Annually, emergency departments are inundated with 12 million persons with mental disorders or SUDs. Persons with these disorders consume 44 percent of all cigarettes. Additionally, 70 percent of persons with significant mental health disorders or SUDs have at least one other chronic health condition, 45 percent have two, and nearly 30 percent have three or more. These are all critical public health issues. They also result in long-term care issues and multiple admissions to the SUDs treatment system.

Actions for Moving the Behavioral Health Care System Forward

Mr. O'Brien concluded his remarks by providing the Summit participants with some thoughts about what needs to be accomplished in the new health care environment, and what the behavioral health field can begin to do now.

What needs to be done? The following actions are needed:

- Identify and agree upon what are “good and modern” services.
- Identify evidence that supports service outcomes.
- Identify services and approaches that should be tested.
- Identify and agree upon 10–20 quality indicators of improvement for an individual.
- Identify strategies to educate persons regarding benefits, enrollment, and continued enrollment.
- Identify provider service delivery strategies that achieve positive outcomes.

“Let us celebrate those in recovery as we recommit ourselves to those still suffering from addiction.”

Jim Ramstad

What can be done now? States should consider the following activities:

- Attend State stakeholder health care reform groups.
- Identify and educate members of the legislature who will be responsible for developing and introducing health care reform legislation.
- Disseminate information from the Federal government that contains opportunities, milestones, dates, and progress of health care reform.
- Remain informed by signing up for information from the executive and legislative branches, as well as constituent groups.
- Join or organize a coalition that reflects your vision and needs.
- Understand key concepts: health care exchanges, health information exchanges, high-risk pools, benchmark plans, and essential benefits.

For persons seeking additional information on the ACA, the following list of Web sites was provided:

- To surf: <http://www.healthcare.gov>
- To watch Webcasts or videos:
<http://www.healthcare.gov/news/videos/index.html>
- To learn about your State’s implementation efforts:
<http://www.healthcare.gov/law/resources/index.html>
- To provide comments on regulation: <http://www.regulations.gov>

The audience was invited to pose questions and to comment following this presentation. Those questions and answers can be found in Appendix B.

Luncheon Presentation: Jim Ramstad, Former Minnesota Congressman



As the chief sponsor of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, and a longtime advocate for treatment of mental illness and SUDs, Mr. Ramstad remarks provided personal insights concerning recovery. Former Congressman Ramstad thanked the Summit participants for their commitment to the behavioral health field, and reinforced the importance of the work they are doing.

He discussed the evolution that has occurred in the national dialogue, in which many now recognize addiction as a brain disease and know that people recover. Further, he said that the effort to shift emphasis from reducing the supply of drugs to fulfilling the demand for treatment and prevention is a significant step in moving the recovery agenda forward.

Although former Congressman Ramstad noted that the stigma associated with addiction and mental illness continues to be pervasive and a major obstacle to recovery, he pointed out that stigma can be overcome by celebrating those in recovery, supporting drug court graduations, and promoting scientific research related to the efficacy of treatment. He concluded his remarks by thanking the participants again for their heroic work on behalf of the millions of Americans who struggle with behavioral health problems.

Breakout Sessions

During the next phase of the Summit, participants discussed and proposed steps to promote long-term recovery for individuals with substance use and co-occurring mental disorders. Participants were asked to select one of 10 breakout groups for participation in a more in-depth discussion of a topical area. Six specific questions guided discussion group dialogue. A list of the 10 breakout sessions and the six questions used to frame the discussion are below:

Breakout Groups

1. Criminal Justice and Juvenile Justice Systems and Recovery
2. Housing Options and Recovery
3. Employment for Individuals in Recovery
4. Collaboration Among the Child Welfare System, Family Courts, and Recovery Community
5. Educational Opportunities for Individuals in Recovery
6. Connecting the Prevention and Recovery Communities
7. Connecting the Faith-Based and Recovery Communities
8. The Role of Peer Services in Recovery
9. Bridging Mental Health Recovery and Addiction Recovery
10. Workforce Development and Recovery: Retooling the Behavioral Health Workforce

Breakout Session Questions

1. What are the primary issues to be addressed in this topic area?
2. What strategies and approaches have you seen as being successful in the field and in communities in this topic area?
3. To what degree have recovery principles been embedded in processes and practices?
4. What are the major challenges and barriers to achieving successful outcomes in this topic area?

5. Which stakeholders have been involved on the Federal, State, and local levels?
6. What specific steps could be taken to move the agenda forward?

Participants became very engaged in this segment of the Summit. It allowed everyone to have a voice as they framed a discussion in response to the four points seen below:

1. an overview of the major issues;
2. how recovery principles have been embedded in process and practices, what challenges and barriers have been encountered, how successful strategies have been implemented, and how stakeholders have been included in processes;
3. common themes; and
4. possible next steps to move the agenda forward.

The following sections summarize the 10 breakout sessions.

1. Criminal Justice and Juvenile Justice Systems and Recovery

The criminal justice and juvenile justice systems offer important environments to address SUDs and foster long-term recovery while addressing public safety. This breakout session discussed how to foster recovery-oriented principles and services for those involved in the criminal justice and juvenile justice systems.

Major issues affecting the promotion of recovery-oriented principles within the criminal justice and juvenile justice systems were readily identified. These issues, which became the common themes in the discussion, were the insufficient availability of services within the criminal justice, juvenile justice, and community-based treatment systems; the intergenerational cycle of trauma, substance use, and incarceration; and the need to eliminate policies that create barriers to recovery.

There is a lack of capacity for those involved with the criminal justice system. Capacity is needed in the prison, jail, and community-based systems to support diversion and reentry programs. The juvenile justice system similarly lacks adequate treatment capacity. Further, it was felt that the juvenile justice system lacks knowledge of the dynamics of adolescent development and age-appropriate rehabilitation. There is a need for comprehensive services and continuity of care, where services follow an individual from institution to community.

The importance of peers providing treatment and recovery support services was discussed. However, policies in the criminal justice system that restrict contact in the community between persons who have felony convictions were cited as

barriers. It was agreed that ongoing work needs to occur to influence the culture of the criminal justice system toward a stronger focus on recovery.

Several successful recovery-oriented strategies were identified. These include drug courts and Winners' Circles; the latter are peer-led recovery groups that help formerly incarcerated persons reestablish themselves in the community. Another successful recovery support strategy was identified as ongoing case management coupled with a postrelease continuum of care.

The breakout group identified a number of next steps:

- Leverage criminal justice funding opportunities (e.g., Criminal Justice Reinvestment Act, Second Chance Act) and the ACA to promote recovery principles and expand the provision of care.
- Provide public education related to exposure to trauma, to help prevent delinquency.
- Examine the barriers that a criminal record can create in various systems (e.g., housing, education, employment), and the implications for the recovering population.
- Establish linkages between State criminal justice and behavioral health information systems, to collect data on recovery outcomes.

2. Housing Options and Recovery

Many people in recovery have a need for access to substance-free, safe, affordable, and stable housing. This session explored how the private and public sectors can work with the organized recovery community and others to provide a range of housing options.

The critical need for available, accessible, and affordable housing options was a common theme in the discussion. Acknowledging that appropriate housing is essential to attain and sustain recovery, the following analogy was adopted: "Housing is to recovery as water is to swimming."

How the private and public sectors can work together to provide a range of housing options was discussed, citing examples such as Oxford House recovery homes, halfway houses, subsidized housing, supportive housing, and recovery homes. Challenges were identified both to organizations that establish recovery housing and to individuals wishing to access housing—particularly the "Not in My Back Yard" (NIMBY) stance.

A second major barrier is a criminal background and the rules that prohibit such persons from accessing voucher opportunities and public housing. Beyond these two primary barriers are additional roadblocks encountered when linking recovery and housing, including predatory housing providers, the overall quality

of housing options, and “competition” for limited appropriate placements. Securing financing for building or remodeling was also identified as a barrier. Persons with special needs may face additional barriers that pertain to accessibility.

It was noted that persons who lack fundamental knowledge of housing policies and procedures may be unable to navigate through the complex systems involved. The group suggested that peers who have successfully negotiated these issues can be a great resource to others.

One successful strategy to enable system navigation was suggested: a searchable, consumer-driven Web site to identify affordable housing options. An example of one that is currently in use is <http://www.findrecoveryhousing.com>, developed by the Connecticut Community for Addiction Recovery (CCAR). It contains information about establishments that provide a pro-recovery environment.

In order to move the housing-related recovery agenda forward, the following next steps were suggested:

- Develop standards for multiple housing models and create a centralized database, using <http://www.findrecoveryhousing.com> as an example.
- Collect and analyze data to display positive outcomes resulting from various housing models.
- Expand support for a continuum of housing options, such as Oxford House homes and other recovery homes.
- Address barriers pertaining to NIMBY issues, criminal history, and families or individuals with special needs.

3. Employment for Individuals in Recovery

Stable and stage-appropriate employment—including job preparation and readiness—and the opportunity to achieve economic self-sufficiency are critical components of recovery. Discussion in this breakout session addressed how the private and public sectors can partner to lift barriers and provide recovery-friendly workplaces.

The common themes that emerged from this breakout group discussion were the need to remove policy barriers and other challenges to employment; the importance of an informed and supportive work environment; and the need for the public and private sectors to create employment opportunities. Recovery involves achieving the maximum amount of independence from one’s addiction, including economic self-sufficiency. Employment was defined as economic self-sufficiency. Further, it was determined that employment involves more than a job; it means the performance of meaningful work, with the opportunity for advancement and the management and accumulation of assets.

People in recovery face significant challenges. For those with a criminal record, finding meaningful employment can be a tremendous struggle. In addition, there are other challenges to employment, including transportation (especially in rural areas), loss of a driver's license, and lack of housing. Other barriers include limits on the extent to which Federal funding sources, such as the Substance Abuse Prevention and Treatment (SAPT) Block Grant, can pay for employment-related expenses; and treatment policies that prohibit employment while in treatment. The current state of the economy and its impact on persons who are already marginalized is a barrier to self-sufficiency as well.

There is a need for a recovery-friendly, inclusive work environment, supported by both public- and private-sector employers. Strategies to support that goal include identifying private-sector business leaders and leaders in State or local governments to champion the issue; use of life coaches or peer-to-peer counseling to guide people in recovery through the challenges of the workplace; and developing supportive work environments as an adjunct to and supported by the treatment agency. A strategy that has proven successful for several treatment and recovery organizations is the development of their own businesses, which provide revenue for their programs, employ persons in recovery, and teach individuals a craft.

The following next steps were suggested to expand employment opportunities for persons in recovery:

- Establish a demonstration or pilot program challenging the public and private sectors to work together to increase employment of people in recovery by 10 percent over 5 years.
- Identify and replicate model employment programs and successful partnerships.
- Acknowledge, analyze, and measure the connection between employment and recovery to convey its worth to private-sector employers.
- Ensure that persons in recovery have meaningful involvement in influencing employment policy and the recovery agenda.
- Eliminate both policy issues, often related to a criminal record, and resource barriers that are hindering employment.

4. Collaboration Among the Child Welfare System, Family Courts, and Recovery Community

Addressing parental histories of addiction and its consequences is a key to healthy family life. This session offered an opportunity for representatives from the organized recovery community, child welfare, and others to discuss barriers to and strategies for reuniting and strengthening the families of individuals in recovery.

Three common themes emerged from the discussion: (1) an individual's addiction has an impact on the person, family, and community; (2) understanding and acceptance of recovery should be fostered through education of all persons responsible for children in the child welfare system; and (3) strengthened cross-systems collaboration between the child welfare and addiction systems should yield improved outcomes for individuals and families.

Concern was voiced over the lack of knowledge within child welfare systems about recovery. This lack of knowledge can lead to unrealistic expectations by the courts and child welfare workers. Additional barriers to recovery for those involved with the child welfare system were also discussed. These barriers include the societal pressure for criminalization of persons with SUDs rather than treatment; trauma and intergenerational family dysfunction; lack of collaboration between systems to obtain housing, education, child care, and employment; lack of treatment options that include the family unit; and lack of resources for children's mental health. These factors also create a barrier to family reunification.

When at all possible, the recovery process should include the family unit, and family-focused services need to be more accessible (e.g., halfway houses and residential family treatment). More attention should be given to providing prevention services to families involved in the child welfare system that are at risk for behavioral health problems. Cross-systems collaboration was seen as essential to create mutual understanding and promote recovery. Specifically, recovery would be promoted by the establishment of an interdisciplinary team that includes parents, recovery coaches, and child welfare and court professionals, and that recognizes recovery principles. Recovery principles are just beginning to be embedded in child welfare-related processes and practices. There have been successful strategies to address substance use and mental health issues in child welfare practice. These strategies include the Administration on Children, Youth and Families' Regional Partnership Grants; model family drug treatment courts; residential treatment settings that include the family unit; use of recovery coaches, including persons in recovery; and leveraging assistance from the faith-based community.

Several ideas to enhance collaboration among child welfare, family courts, and the recovery community were identified:

- Integrate recovery issues into the new Health Resources and Services Administration Maternal, Infant and Early Childhood Home Visiting Program.
- Educate child welfare and court professionals to enhance their focus on recovery issues.
- Identify recovery champions to educate others on the needs of those in recovery.
- Embed recovery principles into cross-systems work through development of a recovery inventory.
- Invite the Administration on Children, Youth and Families to participate in future recovery summits.

5. Educational Opportunities for Individuals in Recovery

Educational opportunities allow people in recovery to realize their intellectual potential, find meaningful work, achieve economic self-sufficiency, and become contributing members of the community. Programs and systems that lift barriers to education and offer recovery-friendly environments for learning and educational achievement were explored in this breakout group.

Two major themes were identified: (1) a national interdisciplinary effort is needed to address recovery barriers in educational settings; and (2) educational settings offer inherent opportunities for prevention, early intervention, and treatment services, and these opportunities should be maximized.

Academic institutions often have difficulty acknowledging and responding appropriately to drug problems. For those institutions that are supporting recovery, issues of funding were identified as barriers. Specifically, insufficient resources are available for educational programs and supports, and funding is often episodic and fragmented. These funding limitations make it difficult to create a quality program that is comprehensive and sustainable. Additionally, students in recovery are sometimes not understood or accepted by classmates due to a lack of knowledge about recovery. Students who have a previous criminal record also encounter barriers when seeking student loans and grants.

The general consensus was that recovery principles are not embedded in the processes and practices of the educational system, but can be found within individual schools. As an example, recovery schools (see <http://www.recoveryschools.org> for more information) embrace the principles of recovery. Other examples include peer-based programs and supports in colleges and high schools, integrated student assistance programs, and credentialed

treatment counselors in schools. These models and services hold great promise for supporting students' recovery. Because the educational system offers a natural opportunity to reach young people in need of prevention, early intervention, and treatment, it was felt that educational settings should provide additional services.

The following potential steps were identified to advance educational opportunities for persons in recovery:

- Develop a resource map of funding, to inform long-term planning and define need for early intervention, treatment, and recovery support within the educational system.
- Establish an early intervention system to support students who are at risk for substance use and mental health problems.
- Create a national steering committee, made up of key stakeholders from the fields of education, mental health, and substance use, to develop a national strategy to support recovery from addiction.
- Establish standards for recovery support within school-based health centers.
- Revive and/or restore student assistance programs with substance use program components.
- Engage nongovernmental entities in public-private partnerships, to enhance funding opportunities to support intervention and recovery efforts in educational settings.

6. Connecting the Prevention and Recovery Communities

The prevention and addiction recovery communities are critical partners, but they have often worked in isolation from one another. This session focused on ways to bridge this gap by developing collaborative efforts to address prevention, addiction, mental health, and wellness in neighborhoods and communities.

The major theme that emerged from this group's discussion was the fact that the substance abuse prevention and recovery communities (addiction and mental health consumers) are often working with the same populations, but are not connected or collaborating. This was attributed in part to differing language, values, and goals.

The recovery and prevention communities each have their own identity. Time needs to be dedicated to understanding and articulating the similarities and differences between the communities, so that these critical partners can work together more effectively.

Wellness was identified as the common ground between the prevention and recovery communities. It is the recovery principle embedded in the processes and practices of both systems. The group suggested that both communities should create opportunities to work together to build on their respective strengths. Cross-training is another way to bridge the prevention and recovery communities' cultural issues.

In both Maine and Tennessee, prevention coalitions and the recovery community have come together. The State of Rhode Island has established the role of a recovery coach for participation in both prevention and recovery task forces. In other locales, coalitions have been developed to address comprehensive behavioral health, rather than segmenting prevention, treatment, recovery, and mental health services. SAMHSA's Strategic Prevention Framework and the adoption of ROSC were suggested as mechanisms to bring stakeholders together across the continuum.

The following are seen as next steps:

- Bring Federal leadership and nongovernmental organizations together for dialogue and to identify common goals and messages between the prevention and recovery communities.
- Frame future discussions of recovery with the prevention community in terms of "wellness," with a focus on building stronger individuals, families, and communities.
- Identify successful community models and programs where the prevention and recovery communities are working together, and disseminate the information for replication.
- Establish a mechanism for cross-training of systems to bridge cultural differences.
- Explore the use of shared mentoring models between prevention and recovery organizations.

7. Connecting the Faith-Based and Recovery Communities

Spirituality and faith are keys to achieving and maintaining recovery for many individuals. This session addressed ways in which the recovery and faith communities can work together to create services that respect the role that faith and spirituality can play in promoting recovery and wellness.

Over the course of this group's discussion, the following themes emerged: the value of a holistic approach to recovery, inclusive of physical, behavioral, and spiritual supports; the need to address the cultural and philosophical differences between the faith and recovery communities; and the need for increased resources to support the work of faith-based organizations.

The “faith-based community” is very diverse and lacks a shared belief regarding the nature of addiction and the best approaches to foster prevention and recovery. This can sometimes make establishing connections between recovery and faith communities challenging. Distrust of government was cited as a barrier to the faith-based community becoming more involved with addiction and recovery issues. Some in the faith community view addiction as a moral issue rather than as a disease, and this has sometimes led to resistance to the use of evidence-based practices. There is also a lack of understanding and appreciation of faith leaders’ power to support recovery. Most agreed that faith communities have not been adequately engaged in supporting recovery, and that there should be a concerted effort to establish a common understanding of recovery principles and to disseminate best practices to faith-based organizations.

The following are strategies to bring the faith-based and recovery communities together: communication, community engagement and participation, capacity building, addressing cultural diversity, and supporting research and dissemination of evidence-based practices.

The steps below would help the faith-based and the recovery communities achieve synergy in service delivery:

- Provide training opportunities for the faith-based community on addiction and recovery.
- Convene faith-based stakeholder focus groups to explore attitudes.
- Ensure that there is at least one faith-based organization involved in every Access to Recovery project.
- Foster openness to diverse spiritual practices and principles in medical, behavioral, and educational initiatives.
- Develop educational materials that explain evidence-based practices, and disseminate these to faith-based organizations.
- Provide capacity-building opportunities for faith-based organizations and interfaith coalitions.

8. The Role of Peer Services in Recovery

Peer services draw from a rich history of mutual support groups in the addiction recovery community and a rich history of services operated by mental health consumers. This discussion resulted in a dialogue about what is needed to further develop peer services as a vital component of support and care in addiction and mental health recovery.

This breakout session identified three major themes. The first theme was sustainability and funding of services, specifically, continued and increased funding for peer recovery support services. The second theme was development

of easily accessible tools and products for the peer workforce. The third theme supported the emergence of effective policy to ensure consistent language and common definitions; collaboration among Federal, State, and local agencies; appropriate allocation of funds; and integration of peer recovery support services into multiple systems.

Selected States understand the need to shift from a focus on treatment planning to recovery planning, and the important role that peer recovery support services play for many individuals seeking and in recovery. Several successful strategies were described that support this approach, including strengthening peer recovery community organizations; instituting outreach efforts to promote social inclusion and prevent discrimination; leadership training for peers and mentors; and continued practice-based and recovery-based research to produce useful tools and materials.

The lack of funding, particularly in the current economic environment, was seen as a significant barrier. Peer recovery support specialists provide vital services in a number of settings, such as mental health/SUDs clinical settings, recovery centers, and consumer-operated agencies. In order to retain qualified peer specialists, adequate funding is needed to appropriately reimburse staff for their services. Existing funding sources appear to impose limitations on funding peer services. The SAPT Block Grant was viewed as somewhat inflexible in funding peer recovery support services—for example, funding services to those who do not seek treatment. The lack of recognition that peer supports are evidence based limits Federal funding sources for these services. A prior criminal conviction was also seen as another barrier to the delivery of peer recovery support services.

Multiple workforce challenges were discussed, including efforts to establish certification for peer recovery support specialists; the need to train peer specialists to deal with diverse and complex populations and problems (i.e., intergenerational trauma); and appropriate supervision to assist peer specialists in the delivery of services and supports.

The following steps can be taken to move the role of peer services in recovery forward:

- Ensure that SAPT Block Grant funding is equitably distributed and clearly permits the funding of recovery support organizations, peer-run services, and recovery support services.
- As a condition of receipt of block grant funding, require establishment of a ROSC that explicitly includes the provision of peer services and the involvement of members of the addiction and mental health recovery community in designing and implementing the ROSC.

- Develop accreditation for recovery organizations and programs and certification for peer recovery support specialists and recovery coaches.
- Build a constituent base to support the recovery agenda.
- Engage NIDA, NIAAA, and NIMH in a recovery roundtable to inform future research efforts.
- Strengthen collaboration between the prevention and recovery communities.

9. Bridging Mental Health Recovery and Addiction Recovery

This session built on a meeting previously sponsored by SAMHSA in August 2010 that was attended by individuals identified as being in recovery from SUDs and mental health disorders. The themes that emerged from this session included the need for education and communication between the mental health and addiction recovery fields; measures across fields to eliminate stigma against those with SUDs and mental health disorders; and additional collaboration among providers, recovery center personnel, communities, peers, family members, and other supporters.

A number of strategies were identified that could enhance the bridge between the mental health and addiction recovery fields. Wellness and personal responsibility are concepts that both systems embrace. The concept of resilience and the skill required to exercise it can be found in both systems and was a basis for common ground. Eva's Village (a social service organization dedicated to fighting homelessness and poverty) and Friends Connection (a mobile psychiatric rehabilitation program) were cited as peer initiatives that include persons from both the mental health and addiction recovery fields. Community education and engagement related to the understanding of mental health and recovery from addiction were also seen as viable strategies to link collaborative efforts. Consistent messaging on the part of Federal officials and availability of integrated training curricula based on research would further link mental health recovery and addiction recovery.

One of the barriers to augmenting the bridge between mental health recovery and recovery from addiction is a lack of understanding between persons working in each system. Another barrier is the financial fear of being subsumed by one system or the other, coupled with the view that mental health may be a more "medicalized" profession than addiction recovery, which has a long history of providing services by people with lived experience. This stance creates a dilemma as each community tries to maintain its identity and resources. Discrimination fueled by stigma plagues those in both the mental health recovery and addiction systems, and it can have a negative rippling effect throughout a variety of community systems and services that hampers recovery.

The following steps would move this agenda forward:

- Promote consistent messaging at the Federal level to ensure that all relevant parties are aware of priorities.
- Facilitate additional collaboration between the mental health and addiction recovery fields, beginning with research-based education and communication.
- Identify common language that addiction and mental health peers and professionals can use.
- Identify a definition of recovery that the mental health and addiction communities have in common.
- Develop and deliver evidence-based and integrated curricula for training in mental health and addiction recovery.
- Seek information on effective peer support initiatives from which the mental health and addiction fields can mutually benefit.

10. Workforce Development and Recovery: Retooling the Behavioral Health Workforce

This session focused on efforts to train addiction and mental health service providers in recovery-oriented approaches, and to promote inclusion of peer and recovery support services in workforce development.

Two broad themes emerged from this breakout group discussion: (1) the need to coordinate services for persons in recovery and (2) the importance of an articulated career path, standardized certification process, and viable technology transfer and skill-building models that aid in staff retention.

A vast number of agencies, organizations, professionals, and peers serve those in recovery. Recovery principles are embedded inconsistently within these agencies. Further, the number of entities involved in supporting those in recovery creates considerable funding competition for limited resources, and often results in a fragmented approach to service provision. Funding constraints, coupled with low salaries, limit the field's ability to recruit and retain trained and skilled personnel. Additionally, the field lacks a uniform credentialing process and an articulated career path for staff.

The session discussion also identified strategies for making the field an attractive place to build a career. It was recognized that peers are playing an expanded and welcome role in the workforce. There was also a discussion of the importance of technology transfer with a focus on skill-based models to bolster the workforce. Ongoing mentoring, coaching, and attentive supervision are mechanisms that can have a positive impact on the workforce. Learning styles

vary greatly among individuals, so the introduction of multiple methods of teaching can enhance the learning curve during training.

Several potential next steps were identified to aid the workforce in supporting recovery:

- Establish a workgroup to develop a plan to further enhance the recovery workforce.
- Establish national standards for certification, training, and recovery outcome measures.
- Establish a national coordinating center for workforce development.
- Conduct a resource assessment to determine all current funding streams linked to the provision of substance use treatment.
- Educate legislators at the Federal and State levels concerning the issues of the workforce.
- Assess and enhance the readiness of primary health care providers to address the needs of those with substance use and co-occurring mental health problems.

PART V: SUMMARY OF THEMES FROM THE SUMMIT



The outcome of the Summit can be summarized as a call for a National Recovery Agenda that provides a unified message to Federal, State, and local agencies about and in support of recovery. To advance the agenda, it was suggested that several areas be addressed. These areas can be categorized as follows: collaboration and coordination, standards, measures and outcomes, innovative practices, social inclusion, and training and education. Additional detail regarding the Summit participants' thoughts on the National Recovery Agenda appears below.

National Recovery Agenda

The fundamental goal of the National Recovery Agenda should be the promotion of principles and a unified message of recovery within Federal, State, and local agencies across the country. Consistent with a recovery-oriented approach, persons in recovery should be involved in developing and implementing the agenda. The agenda would address Federal and State policy barriers related to housing, employment, and student educational aid for persons with criminal justice histories. A major tenet of the agenda is the elimination of discrimination, and an expanded focus on social inclusion for those with SUDs and mental disorders. The agenda would further define the resources and collaborations that are necessary to promote recovery across the nation. The following resources are needed to ensure that organizations are equipped to deliver quality recovery-oriented services: education and training in multiple health and human service agencies; enhanced treatment and recovery support capacity; and additional program development. Lastly, the agenda would establish accountability measures, particularly recovery measures, to assess performance.

Collaboration and Coordination

Multiple health and human service agencies, businesses, and community organizations play a role in supporting healthy lifestyles and promoting recovery. The importance of coordination across Federal, State, and local agencies was emphasized, with the goal of supporting a consistent recovery agenda that addresses social and policy barriers and provides essential services. Through a National Recovery Agenda, additional coordination within the public sector as well as cross-collaboration among public and private sectors could be promoted. Coordination would stimulate the identification of common goals and promotion of consistent messaging to support recovery.

Better coordination and integration of services would strengthen the results of the prevention, treatment, and recovery communities—who often work with the same populations. Through collaborations, partners establish a joint mission, maximize their assets, and avoid duplication of effort. A strategy to encourage collaboration and promote change is to engage “champions” who are in long-term recovery. Involvement of consumers, peers, and family members in discussions and decision-making processes is essential, due to their important role in supporting individual recovery and in creating a ROSC.

Standards

A National Recovery Agenda should establish the framework for creating recovery-oriented standards of practice. Standards of practice guide whether services are delivered appropriately. The development process should begin with establishing consistent terminology. Establishing a glossary of standardized treatment and recovery terms, inclusive of recovery principles, was seen as a vital step in developing a common language across organizations. Credentialing standards should also be developed for peer support service providers (e.g., peer recovery support specialists and recovery coaches) to further legitimize the inclusion and funding of these services in prevention, treatment, and recovery systems. Lastly, consistent training standards based on evidence-based practices and recovery principles are essential to developing coherent messages related to recovery and improving the quality of care within the prevention, treatment, and recovery communities.

Measures and Outcomes

Establishing recovery outcome measures that gauge system performance was a frequent theme in the discussion. Outcomes, such as obtaining safe and affordable housing, gaining employment with opportunities for

advancement, and attending educational programs, were seen as important components to long-term recovery. Further, the systematic collection and analysis of client outcome data for service delivery and for systems improvement were viewed as important items that should be addressed in the National Recovery Agenda. Effective outcomes collection requires extensive collaborations across various health and human service systems, and the agenda can assist in furthering and promoting this effort. Once more readily available, recovery outcomes should be disseminated to policymakers, employers, educators, and the public.

Innovative Practices

Research-based practices and innovations were seen as important in the advancement of a National Recovery Agenda. Summit participants voiced the need to identify and disseminate evidence-based practices and promising practices—practices that appear to be having a positive effect on recovery even though the evidence has not been fully established. Successful partnerships should be identified and replicated, so that those invested in recovery can learn from each other. Models, programs, and best practices should be collected and a database developed to allow dissemination and evaluation of the usefulness of these resources. The research community should be engaged to further support recovery. NIDA, NIAAA, and NIMH should be encouraged to conduct a roundtable on future research efforts related to recovery.

Social Inclusion

The Summit participants articulated a need to cultivate an informed and supportive public perception of those in addiction and mental health recovery. Negative perceptions and disparities continue to exist for people with SUDs and mental disorders—both in the general public and across multiple systems. A National Recovery Agenda would provide the platform to change this perception. In response to these issues, the often negative terminology used to describe persons in or seeking recovery should be changed to convey “wellness” and promote healthier individuals, families, and communities. Barriers, often associated with a prior criminal record, should be examined so they can be removed.

People in recovery should not be repeatedly penalized for past crimes for which they have completed their sentences. Summit participants emphasized the importance of providing pre-sentencing opportunities, when appropriate, to address addictions and to prevent labeling someone with a felony conviction for the rest of his or her life.

Training and Education

The need for training and education was a theme throughout many of the Summit discussions, and viewed as essential to advancing a National Recovery Agenda. Recovery principles training is needed across the substance use prevention, treatment, and recovery field, and also within various health and human service agencies that play a role in supporting recovery. Education of Federal, State, and local leaders (e.g., drug court officials, child welfare personnel, staff in the juvenile justice and criminal justice systems, legislators, faith-based leaders, and educators) about recovery principles, will create a unified message and support social inclusion for persons in recovery.

Skills training related to cultural competence, evidence-based practices, trauma-informed care, and peer-based services should be further enhanced. Cross-training between the mental health and SUDs fields and between the prevention and recovery fields is also necessary to promote understanding, collaboration, and a recovery agenda.



Closing Remarks: David Mineta, Deputy Director of Demand Reduction, ONDCP

Deputy Director Mineta closed the Summit by expressing gratitude to the participants for their good work, and thanking SAMHSA for co-sponsoring the Summit with ONDCP. He also extended appreciation to the Department of Education for their contributions to the Summit. Deputy Director Mineta referenced ONDCP's 2010 National Drug Control Strategy, which marks a new direction in drug policy issues. The strategy includes integration of substance use disorders treatment into mainstream health care, and the use of innovative criminal justice initiatives that break the cycle of drug use, crime, and incarceration. He also acknowledged the larger role of recovery within ONDCP, and the significant progress made in promoting recovery since the 2005 National Summit on Addiction Recovery. He stated that thanks to the efforts of the Summit participants and years of work, a branch on recovery would soon be created within ONDCP. Deputy Director Mineta ended his remarks by reflecting upon the hope and courage he finds in families and individuals who are spreading the message of recovery across the country.

“It is the stories of hope and recovery that motivate us and keep us focused and moving forward.”

David Mineta

APPENDIX A: AGENDA

National Summit on Recovery From Substance Use Disorders

September 14, 2010

Washington Plaza Hotel - 10 Thomas Circle, Washington, DC, N.W.

- 7:30 to 8:30 a.m. Registration**
- 8:30 to 8:40 a.m. Welcome/Introduction**
H. Westley Clark, MD, JD, MPH, CAS, FASAM,
Director, Center for Substance Abuse Treatment (CSAT)
- 8:40 to 9:15 a.m. Opening Remarks**
- R. Gil Kerlikowske, Director, Office of National Drug Control Policy (ONDCP)
- Pamela Hyde, JD, Administrator, Substance Abuse and Mental Health Services Administration (SAMHSA)
- Kevin Jennings, MA, MBA, Assistant Deputy Secretary of Education, Office of Safe and Drug-Free Schools (OSDFS)
- 9:15 to 10:45 a.m. Panel Discussion and Reflections: What Has Changed Since the Last Recovery Summit**
- Moderator: Ivette A. Torres, MEd, MSc, Associate Director of Consumer Affairs, Center for Substance Abuse Treatment (CSAT)
- Panelists:**
- Tom Hill, MSW, Director of Programs, Faces and Voices of Recovery (FAVOR)
- Larry Fricks, Director, Appalachian Consulting Group, and Vice President of Peer Services for the Depression and Bipolar Support Alliance (DBSA)
- Arthur Evans, PhD, Commissioner, Philadelphia Department of Behavioral Health and Intellectual disAbility Services
- Audience Discussion, Questions, and Comments*

- 10:45 to 11:00 a.m.** **Break**
- 11:00 to 12:00 p.m.** **A Dialogue on the Implications of Health Care Reform**
John O'Brien, MA, Senior Advisor for Health Finance, SAMHSA
Question and Answers
- 12:00 to 2:00 p.m.** **Luncheon Presentation**
Jim Ramstad, Former Member of Congress, State of Minnesota
- 2:00 to 4:00 p.m.** **Breakout Sessions**
- 4:00 to 4:15 p.m.** **Break**
- 4:15 to 4:45 p.m.** **Highlights From the Breakout Groups**
- 4:45 to 5:00 p.m.** **Closing Remarks**
David Mineta, MSW, Deputy Director of Demand Reduction, ONDCP
- 5:30 to 7:30 p.m.** **Reception at Decatur House**
748 Jackson Place, N.W., Washington, DC

APPENDIX B: QUESTIONS AND ANSWERS

National Summit on Recovery From Substance Use Disorders

Panel Discussion and Reflections: What Has Changed Since the Last Recovery Summit—Questions and Answers

Panel members included Arthur Evans, Commissioner, Philadelphia Department of Behavioral Health and Intellectual disAbility Services; Tom Hill, Director of Programs, Faces and Voices of Recovery; and Larry Fricks, Director, Appalachian Consulting Group, and Vice President of Peer Services for the Depression and Bipolar Support Alliance.

Priorities of Recovery Communities in the New Health Care Reform Environment

Q. *Knowing what we know today about systems change, what should be the priorities of recovery communities in the addiction and mental health fields during the health care reform systems transformation?*

A. Arthur Evans: One key issue is the integration of behavioral health with primary care and how we handle that as a field. I believe there is a need for different models of integration. I think there are multiple ways to do this, not just placing behavioral health care into primary care settings. We need to determine which model works best for people. We must look to those in the field to articulate the most effective models.

Tom Hill: We need to figure out how we are going to fit into the larger system of care. We offer a perspective that has not been embraced by primary care, but we are coming into the system with something to learn, and also something to teach.

Larry Fricks: There is a realization that prevention is a big part of health care reform. We have a history of addressing prevention as well as treatment of behavioral health disorders, and we need to share our experience and knowledge.

Families, Adolescents, and Children

Q. *The fastest-growing group of people in treatment for substance abuse is young women 14–24 years of age. I am concerned about the children of this growing population of women. How can we use prevention more effectively with children whose families have already been affected by addiction?*

A. Arthur Evans: If we're serious about recovery and people living productive lives in the community, there has to be a strategy around children and families, and a strategy that includes the community. Prevention must be a key part of that strategy. One of the things we don't pay enough attention to is

the communities that we are sending recovering people back to. We have to broaden our thinking about families and communities, and intervene in these areas. Often people are not supported, I think it is important that we educate and partner with a variety of community and faith based organizations to assist them in supporting recovering people.

Q. Could you speak about recovery and adolescence and about child welfare?

A. Tom Hill: One of the breakout sessions addresses child welfare concerns for people in recovery, especially women who are reclaiming their children while in recovery—and I look forward to the suggestions that will come out of that session about how to address this issue. Regarding the issue of adolescence, we are on the frontier of really embracing young people in recovery as part of our community. The prevention-oriented recovery movement in schools is a good first step to foster engagement of youth.

Challenges—Past and Present

Q. What are the most difficult challenges that you encountered in the process of establishing your recovery-oriented systems of care (ROSC)?

A. Arthur Evans: For systems administrators and policymakers, dealing with trauma and applying evidence-based practices are fundamental concerns. Systems change requires that time and attention be paid to educating people about the reason and purpose for new approaches. An inclusive process is needed and we need to work hard to ensure that all stakeholders are in the room to help develop the programs and approaches that are needed. Transformation is a slow process, but it is absolutely essential.

Q. I would like to hear how you think we should be responsive to the needs of people with physical and sensory disabilities.

A. Arthur Evans: It is difficult to develop a system that has a continuum of care that addresses the full range of needs that people have. To ensure that systems are effective, administrators must ensure the input of those affected by physical disabilities, their families, professionals and other community stakeholders.

Q. What will it take to bring about support for people in recovery from mental health disorders? How do we deal with stigma?

A. Larry Fricks: Continued expansion of peer-operated services will support people in recovery. Inclusion of people in recovery is vital. Consumers should be in leadership positions on boards, etc. “Nothing about us, without us,” is the mantra. Peers can help reduce stigma by helping others and serving as role models. In her book, Rosalynn Carter makes a point that there are strengths and skills that recovering people can use to help others.

A Dialogue on the Implications of Health Care Reform – Questions and Answers

Questions directed to John O'Brien, Senior Advisor for Health Finance, SAMHSA

Q. How does SAMHSA envision establishing service standards?

A. Although SAMHSA is not using the term “standards,” we are very concerned about creating clarity in describing services for payers. Working internally and now with stakeholders, service definitions are being developed in the areas of individual prevention, recovery support services (both [mental health] and SUD), and for child and adolescent services. SAMHSA wants to promote these three areas by answering these questions: What are the services? Who can provide these services? How do we judge competency?

Q. Can you describe what is happening with medical homes?

A. Medical homes are one way to deal with multiple health problems, involving both medical and behavioral health. We realize there is a lot of confusion about medical homes or health homes. We are trying to disseminate a common description to eliminate confusion over this issue. We are also working to determine how States can apply for funds to implement Medical homes.

Q. Regarding integration and collaboration with primary care, can you talk about the issue of medical records?

A. The behavioral health field will have to determine how to implement electronic health records. It costs money and takes time, but it is essential if we are going to be able to communicate with primary care providers. Currently, only about 20% of behavioral health providers have some electronic record management, and this must change rather quickly.

Q. Peer-to-peer models are important to the field. Do you have suggestions about effective strategies that utilize peers, given the new health care environment?

A. SAMHSA is interested in expanding and defining the role of peers and in using peers as system navigators. One area that peers can assist with is health care enrollment issues. SAMHSA is currently developing models utilizing peer-to-peer interaction that can be purchased with Block Grant dollars and marketed to providers. Recovery models currently used for cancer or diabetes can be helpful in the development of similar models for behavioral health.

Q. I've heard a lot of fear from providers about integrating behavioral health with primary care. Do you agree that this is not a time to be afraid, but rather a time for real opportunity?

A. I agree. There is a lot of consternation about the health care system changes; but I think we have to approach this positively. To the extent that we provide value, we should communicate that information to primary care providers without fear.

APPENDIX C: PARTICIPANT LIST

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September 14, 2010

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