

National Summit on Recovery

Conference Report

Washington, D.C.
September 28-29, 2005

**Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services
Center for Substance Abuse Treatment**

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Disclaimer

The opinions expressed herein are the views of the participants at CSAT's National Summit on Recovery and adjunctive meetings and do not necessarily reflect the official position of CSAT, SAMSHA, or DHHS. No official support of or endorsement by CSAT, SAMHSA, or DHHS for these opinions or for particular instruments, software, or resources described in this document are intended or should be inferred. Nothing in this document should be considered as a substitute for individualized client care and treatment decisions.

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A Note on the Graphic

Members of the June 13-14, 2005 Planning Group were guided through a process that resulted in a large pictorial representation of major recovery issues and themes. Portions of this pictorial representation are presented on the front cover and throughout the report.

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Part I: Overview

Guiding principles of recovery and elements of recovery-oriented systems of care for people with a substance use disorder¹ (SUD) were articulated by leaders of the treatment and recovery field at the 2005 National Summit on Recovery convened by the Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) Center for Substance Abuse Treatment (CSAT). Transformative ideas and concrete recommendations for advancing the development of such systems of care also emerged from the Summit. This was the first time a broad-based consensus on guiding principles of recovery and elements of recovery-oriented systems was reached on a national level.

Support for the National Summit on Recovery was provided jointly by two SAMHSA/CSAT initiatives, the Recovery Community Services Program and the Partners for Recovery initiative.

Summit Goals

CSAT had three goals for the National Summit on Recovery:

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

Summit Participants

The Summit brought together a diverse group of over 100 stakeholders, such as recovering individuals, family members, mutual aid organizations, systems professionals and treatment providers. Over half identified themselves as people in recovery. Participants also represented many different stakeholder groups, defined by characteristics such as:

- # Race or ethnicity (African American, Asian American, Caucasian, Native American, Hispanic/Latino)
- # Co-occurring conditions (mental health disorders including trauma)

¹ “Substance use disorder” is used here as a term of convenience, and is meant as a broad and encompassing term that includes alcohol and drug problems whether viewed as a disease or in another conceptual framework. CSAT recognizes that there are several terminologies—such as substance abuse, addiction, and others—that might be applied, and respects that some individuals and communities may choose to use different terminologies.

- # HIV/AIDS and other infectious diseases
- # Criminal justice involvement
- # Stage in the life cycle (adolescents, adults and the elderly)
- # Professional and/or community affiliation (systems professionals, treatment providers, researchers, evaluators, recovery support service providers, mutual aid groups and recovery advocates)
- # Approaches to recovery, including secular, faith-based and medication-assisted.

The Summit was designed to enable these diverse participants to interact and engage in dialogue. Many schools of thought and unique perspectives were represented, and participants did not always agree. However, they demonstrated an exceptional willingness to find common ground on recovery topics. Appendix 1 lists the participants.

A Strategically Planned Summit

The first National Summit on Recovery was a process, not an event. The process included a stakeholders' planning meeting, CSAT planning activities and materials development, the Summit itself and a follow-up meeting. Appendix 2 contains agendas for each of the three Summit meetings.

Summit Planning Meeting, June 13–14, 2005

Twenty stakeholders helped SAMHSA/CSAT frame questions and shape an agenda for the Summit. Participants were instrumental in designing a process that would maximize the contributions of attendees from diverse groups and foster shared support for ideas and recommendations for moving toward recovery-oriented systems of care.

The planning group reviewed and approved materials that had been sent to them in advance to help frame the discussions including Appendix 3, Background Paper: Recovery Themes, as well as preliminary research on guiding principles of recovery and elements of recovery-oriented systems of care. Appendix 4 contains National Outcome Measures identified by SAMHSA.

Meeting planners and facilitators were encouraged to develop an interactive agenda permitting all perspectives and stakeholder groups to be heard and smaller structured discussions to take place.

The planning group identified the following types of breakout groups: (1) participants viewing recovery and systems of care from a similar perspective, designated as "lens groups" and (2) stakeholder groups in the treatment and recovery field:

- # Lens groups: Participants who were asked to view treatment and recovery processes through one of six lenses: (1) cultural relevance, (2) person-centeredness, (3) spirituality, (4) wellness, (5) treatment and (6) measurement.

- # Stakeholder groups: Stakeholders from the treatment and recovery field who would be best positioned to effectuate change: (1) systems professionals, (2) treatment providers, (3) researchers and evaluators, (4) recovery support services providers, (5) mutual aid groups and (6) recovery advocates.

In addition, the planning group decided that a breakout group would be invited to develop various graphics that could capture, in a visual fashion, the ideas being explored at the Summit.

National Summit, September 28–29, 2005

The agenda for the Summit included plenary presentations and a recovery panel, and is included in Appendix 5; however, the majority of time was devoted to interactive breakout activities in lens groups and stakeholder groups in which participants engaged in structured discussions of their ideas for moving toward recovery-oriented systems of care. The two-day meeting concluded with the stakeholder groups recommending steps to be taken to move toward recovery-oriented systems of care.

Follow-up Meeting, December 14–15, 2005

The planning group reconvened to review and synthesize the ideas from the Summit and develop recommendations for actions within each stakeholder group and at CSAT. Participants were given draft briefs summarizing the thinking of Summit participants on guiding principles of recovery and elements of recovery-oriented systems of care and recommendations for moving forward. The planning group's task was to validate and/or modify the draft briefs to ensure that the final report on the National Summit on Recovery fully and accurately reflected the diverse perspectives of participants. In response to recommendations from Summit participants, the planning group developed a working definition of recovery that could be used across systems, programs and stakeholder groups.

Guide to Conference Report

The synthesis of ideas and recommendations emerging from the Summit are presented in Parts II and III:

- # Part II: Guiding Principles of Recovery and Elements of Recovery-Oriented Systems of Care
- # Part III: Recommendations for the Treatment and Recovery Field

This synthesis represents the best thinking of the Summit participants. It highlights principles that support recovery-oriented systems of care and suggests steps that the treatment and recovery field can take in the next year to move forward.

Part II: Guiding Principles of Recovery and Elements of Recovery-Oriented Systems of Care

The concept of recovery lies at the core of SAMHSA's mission, and fostering the development of recovery-oriented systems of care is a SAMHSA priority. The working definition of recovery, guiding principles of recovery and elements of recovery-oriented systems of care that were developed through the Summit process provide a philosophical and conceptual framework to guide SAMHSA and other stakeholder groups and offer a shared language for dialogue among stakeholders. Although the substance use disorder treatment and recovery field has discussed and lived recovery for decades, this Summit represents the first broad-based national effort to reach a common understanding of the guiding principles of recovery and elements of systems of care and to define recovery.

The development of guiding principles and elements emerged from a multistage process, which began with a literature review, followed by a first draft of guiding principles of recovery and elements of recovery-oriented systems of care and review of the initial draft by the Summit Planning group. The documents were revised to reflect planning group input and mailed in advance of the Summit to those invited to participate. Participants in the Summit were asked:

- # What principles of recovery should guide the field in the future?
- # What ideas could help make the field more recovery oriented?

Based on contributions from those attending the Summit, the guiding principles and elements were further revised and a briefing report was prepared for attendees at the Summit follow-up meeting. The guiding principles and elements were reviewed and refined a third and final time during the follow-up meeting. Responding to recommendations from the Summit attendees, the participants at the follow-up meeting also developed a working definition of recovery.

While there was consensus among participants at the follow-up meeting on a working definition of recovery and among the Summit participants on the guiding principles of recovery and systems of care elements, two important points also were recognized by stakeholders:

- # Individuals may choose to define recovery differently.
- # Not all guiding principles apply to all people, and different guiding principles may apply at different points in the recovery process.

Stakeholders agreed that recovery is a complex and dynamic process and that race, ethnicity, gender, sexual orientation, family history, life-cycle stage, environment, culture and other factors combine with an individual's unique experiences, strengths, values, perspectives, needs and desires to yield a recovery process unique to each person.

The working definition of recovery, guiding principles and systems of care elements have a unique foundation in their grounding not only in a review of relevant literature, but also in the experience of recovering people, treatment and recovery support workers and many others. The working definition, guiding principles and systems of care elements will become part of CSAT's ongoing dialogue with the substance use disorder treatment and recovery field, policymakers,

Congress and the public, and will be reflected in speeches, program announcements and other forms of public communication. These defining elements will also be discussed in publications, may be considered as standards or criteria against which service models and products can be evaluated or developed and may also be used for in-service training.

The working definition, guiding principles and system of care elements provide States, treatment and recovery support providers, recovering individuals, family members, researchers and other stakeholders with a shared framework from which to begin dialogue.

The following sections detail the guiding principles and elements of recovery-oriented systems of care that emerged from the Summit. These sections are introduced by the working definition of recovery developed at the follow-up meeting and are followed by a brief discussion of the deliberations of the Summit participants who considered various ways of representing these ideas visually.

“The Federal government can play a critical role by crafting messages that treatment works, that recovery is real and that peers play a critical role in fostering resilience and embodying a message of hope.”

–H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM
Director, Center for Substance Abuse Treatment

A. A Working Definition of Recovery

A frequent recommendation from the Summit participants was that CSAT take the initiative in asking the treatment and recovery field to develop a shared definition of recovery that can be used across systems, programs and stakeholder groups. CSAT, in turn, asked the participants at the follow-up meeting to submit, for consideration by the field, a working definition that reflected the tenor of the Summit deliberations. Working from two sample definitions, the group developed the following:

Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness and quality of life.

B. Guiding Principles

The guiding principles that emerged from the Summit are broad and overarching, intended to give general direction to SAMHSA and other stakeholder groups as the treatment and recovery field moves toward operationalizing recovery-oriented systems of care and developing core measures and evidence-based practices. The principles also helped Summit participants define the elements of recovery-oriented systems of care that are identified in Part II-C of this report, and served as a foundation for the recommendations to the field contained in Part III.

There are many pathways to recovery. Individuals are unique with specific needs, strengths, goals, health attitudes, behaviors and expectations for recovery. Pathways to recovery are highly personal, and generally involve a redefinition of identity in the face

of crisis or a process of progressive change. Furthermore, pathways are often social, grounded in cultural beliefs or traditions and involve informal community resources, which provide support for sobriety. The pathway to recovery may include one or more episodes of psychosocial and/or pharmacological treatment. For some, recovery involves neither treatment nor involvement with mutual aid groups. Recovery is a process of change that permits an individual to make healthy choices and improve the quality of his or her life.

- # **Recovery is self-directed and empowering.** While the pathway to recovery may involve one or more periods of time when activities are directed or guided to a substantial degree by others, recovery is fundamentally a self-directed process. The person in recovery is the “agent of recovery” and has the authority to exercise choices and make decisions based on his or her recovery goals that have an impact on the process. The process of recovery leads individuals toward the highest level of autonomy of which they are capable. Through self-empowerment, individuals become optimistic about life goals.
- # **Recovery involves a personal recognition of the need for change and transformation.** Individuals must accept that a problem exists and be willing to take steps to address it; these steps usually involve seeking help for a substance use disorder. The process of change can involve physical, emotional, intellectual and spiritual aspects of the person’s life.
- # **Recovery is holistic.** Recovery is a process through which one gradually achieves greater balance of mind, body and spirit in relation to other aspects of one’s life, including family, work and community.
- # **Recovery has cultural dimensions.** Each person’s recovery process is unique and impacted by cultural beliefs and traditions. A person’s cultural experience often shapes the recovery path that is right for him or her.
- # **Recovery exists on a continuum of improved health and wellness.** Recovery is not a linear process. It is based on continual growth and improved functioning. It may involve relapse and other setbacks, which are a natural part of the continuum but not inevitable outcomes. Wellness is the result of improved care and balance of mind, body and spirit. It is a product of the recovery process.
- # **Recovery emerges from hope and gratitude.** Individuals in or seeking recovery often gain hope from those who share their search for or experience of recovery. They see that people can and do overcome the obstacles that confront them and they cultivate gratitude for the opportunities that each day of recovery offers.
- # **Recovery involves a process of healing and self-redefinition.** Recovery is a holistic healing process in which one develops a positive and meaningful sense of identity.
- # **Recovery involves addressing discrimination and transcending shame and stigma.** Recovery is a process by which people confront and strive to overcome stigma.
- # **Recovery is supported by peers and allies.** A common denominator in the recovery process is the presence and involvement of people who contribute hope and support and suggest strategies and resources for change. Peers, as well as family members and other allies, form vital support networks for people in recovery. Providing service to others

and experiencing mutual healing help create a community of support among those in recovery.

Recovery involves (re)joining and (re)building a life in the community. Recovery involves a process of building or rebuilding what a person has lost or never had due to his or her condition and its consequences. Recovery involves creating a life within the limitation imposed by that condition. Recovery is building or rebuilding healthy family, social and personal relationships. Those in recovery often achieve improvements in the quality of their life, such as obtaining education, employment and housing. They also increasingly become involved in constructive roles in the community through helping others, productive acts and other contributions.

Recovery is a reality. It can, will, and does happen.

C. Systems of Care Elements

Participants at the National Summit on Recovery agreed that recovery-oriented systems of care are as complex and dynamic as the process of recovery itself. Recovery-oriented systems of care are designed to support individuals seeking to overcome substance use disorders across the lifespan. They are comprehensive, flexible, outcomes-driven and uniquely individualized, offering a fully coordinated menu of services and supports to maximize choice at every point in the recovery process.

Participants at the Summit also declared, “There will be no wrong door to recovery.” The attendees recognized that some people recover “naturally,” without any apparent reliance on treatment, mutual aid, or other formal supports, while many others enter recovery through mutual aid groups and/or faith communities. Yet other individuals enter recovery through substance use disorder treatment. The Summit participants noted that a variety of factors, including the severity of substance use disorders, age, culture and the presence of co-occurring physical or mental health problems or involvement with the criminal justice system can influence which of these paths an individual chooses. Participants also recognized that recovery-oriented systems of care need to provide “genuine, free and independent choice” (SAMHSA 2004) among an array of treatment and recovery support options and that services should optimally be provided in flexible, unbundled packages that evolve over time to meet the changing needs of recovering individuals.

Person-centered. Recovery-oriented systems of care will be person-centered. Individuals will have a menu of stage-appropriate choices that fit their needs throughout the recovery process. Choices can include spiritual supports that fit with the individual’s recovery needs.

Family and other ally involvement. Recovery-oriented systems of care will acknowledge the important role that families and other allies can play. Family and other allies will be incorporated, when appropriate, in the recovery planning and support process. They can constitute a source of support to assist individuals in entering and maintaining recovery. Additionally, systems need to address the treatment, recovery and other support needs of families and other allies.

- # **Individualized and comprehensive services across the lifespan.** Recovery-oriented systems of care will be individualized, comprehensive, stage-appropriate, and flexible. Systems will adapt to the needs of individuals, rather than requiring individuals to adapt to them. They will be designed to support recovery across the lifespan. The approach to substance use disorders will change from an acute-based model to one that manages chronic disorders over a lifetime.
- # **Systems anchored in the community.** Recovery-oriented systems of care will be nested in the community for the purpose of enhancing the availability and support capacities of families, intimate social networks, community-based institutions and other people in recovery.
- # **Continuity of care.** Recovery-oriented systems of care will offer a continuum of care, including pretreatment, treatment, continuing care and support throughout recovery. Individuals will have a full range of stage-appropriate services from which to choose at any point in the recovery process.
- # **Partnership-consultant relationships.** Recovery-oriented systems of care will be patterned after a partnership-consultant model that focuses more on collaboration and less on hierarchy. Systems will be designed so that individuals feel empowered to direct their own recovery.
- # **Strength-based.** Recovery-oriented systems of care will emphasize individual strengths, assets and resiliencies.
- # **Culturally responsive.** Recovery-oriented systems of care will be culturally sensitive, competent and responsive. There will be recognition that beliefs and customs are diverse and can impact the outcomes of recovery efforts. In addition, the cultures of those who support the recovering individual affect the recovery process.
- # **Responsiveness to personal belief systems.** Recovery-oriented systems of care will respect the spiritual, religious and/or secular beliefs of those they serve and provide linkages to an array of recovery options that are consistent with these beliefs.
- # **Commitment to peer recovery support services.** Recovery-oriented systems of care will include peer recovery support services. Individuals with personal experience of recovery will provide these valuable services.
- # **Inclusion of the voices and experiences of recovering individuals and their families.** The voices and experiences of people in recovery and their family members will contribute to the design and implementation of recovery-oriented systems of care. People in recovery and their family members will be included among decision-makers and have oversight responsibilities for service provision. Recovering individuals and family members will be prominently and authentically represented on advisory councils, boards, task forces and committees at the Federal, State and local levels.
- # **Integrated services.** Recovery-oriented systems of care will coordinate and/or integrate efforts across service systems to achieve an integrated process that responds effectively to the individual's unique constellation of strengths, desires and needs.
- # **Systemwide education and training.** Recovery-oriented systems of care will ensure that concepts of recovery and wellness are foundational elements of curricula,

certification, licensure, accreditation and testing mechanisms. The workforce also requires continual training, at every level, to reinforce the tenets of recovery-oriented systems of care.

- # **Ongoing monitoring and outreach.** Recovery-oriented systems of care will provide ongoing monitoring and feedback with assertive outreach efforts to promote continual participation, re-motivation and reengagement.
- # **Outcomes driven.** Recovery-oriented systems of care will be guided by recovery-based process and outcome measures. These measures will be developed in collaboration with individuals in recovery. Outcome measures will reflect the long-term global effects of the recovery process on the individual, family and community, not just remission of biomedical symptoms. Outcomes will be measurable and include benchmarks of quality-of-life changes.
- # **Research based.** Recovery-oriented systems of care will be informed by research. Additional research on individuals in recovery, recovery venues and the processes of recovery, including cultural and spiritual aspects, is essential. Research will be supplemented by the experiences of people in recovery.
- # **Adequately and flexibly financed.** Recovery-oriented systems of care will be adequately financed to permit access to a full continuum of services, ranging from detoxification and treatment to continuing care and recovery support. In addition, funding will be sufficiently flexible to permit unbundling of services, enabling the establishment of a customized array of services that can evolve over time in support of an individual's recovery.

D. Visually Representing Recovery and Recovery-Oriented Systems of Care

One breakout group convened to consider ways of visually representing the complex and dynamic principles that guide recovery, and that drive systems of care designed to help people achieve and sustain it. The participants reviewed visual representations by a number of authors, and four of these are presented in Appendix 6. While all the depictions were seen as valuable, the consensus of the participants was that a three-dimensional model was necessary to depict all the layers and complexities of recovery.

Core criteria identified by the group included: Whose perspective does the graphic reflect? Who is the target audience? What is its central informational/emotional message? What effect is this message likely to have on the target audience?

The group recommended that future efforts to develop a visual representation of recovery and recovery-oriented systems of care consider utilizing a series of overlays that captures recovery on at least three levels: the individual, the individual within his or her natural environment and the individual (located within his or her environment) as the center of systems of care.

Part III: Recommendations for the Treatment and Recovery Field

The Summit planners and participants agreed that developing recovery-oriented systems of care would require the commitment and contributions of stakeholder groups, including:

- # Systems professionals
- # Treatment providers
- # Recovery support service providers
- # Researchers and evaluators
- # Mutual aid groups
- # Recovery advocates.

To generate concrete recommendations for the treatment and recovery field, participants convened in stakeholder groups to consider key questions:

- # What does this stakeholder group currently contribute toward creating recovery-oriented systems of care?
- # What more could this stakeholder group do to advance recovery-oriented systems of care?
- # What are three strategies for advancing the goal of a change to recovery-oriented systems of care?

They also convened in mixed stakeholder groups to consider other questions:

- # What would integrated recovery-oriented systems of care look like?
- # Where are current examples of cross-group integration or cooperation?
- # How could those efforts bridge to new kinds of collaboration?
- # What are the major hurdles to achieving this vision?
- # What ideas, if implemented, could move beyond those hurdles?

After the Summit, key recommendations were identified and listed for each stakeholder group. A briefing report on recommendations, by stakeholder group, was prepared for the follow-up meeting.

The planning group reviewed, consolidated, revised and prioritized the recommendations that had been generated by the single and mixed stakeholder groups at the Summit. In addition, the stakeholder group recommendations were enriched by a “fishbowl” process where two representatives of each stakeholder group shared their thinking about which recommendations needed priority attention, and identified:

- # Important partners whose support would be needed
- # Places where discussions needed to occur

Products that could be developed to support the process.

After each stakeholder group completed its presentation, the planning group gave feedback.

The following sections outline recommended next steps for CSAT and each of the stakeholder groups represented at the National Summit on Recovery. These next steps were envisioned as part of an overall process of operationalizing and developing core measures and evidence-based practices for recovery-oriented systems of care.

Recommended Next Steps for Consideration by CSAT

- # Inventory current programs and practices throughout CSAT to determine strengths and gaps from a recovery-oriented perspective.
- # Convene a full-day summit attended by researchers to discuss research strategies and formulate an integrated research agenda. This summit would be attended by researchers from the National Institute on Drug Abuse (NIDA), the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute of Mental Health (NIMH) and community-based researchers, as well as by representatives of CSAT and the Center for Mental Health Services (CMHS).
- # Use the development of the “social connectedness” National Outcomes Measures (NOMs) domain as an opportunity to further align NOMs with the guiding principles of recovery and elements of recovery-oriented systems of care identified at the Summit.
- # Conduct outreach with other national organizations whose support for recovery-oriented systems of care will be instrumental.
- # Convene a series of regional meetings on recovery-oriented systems of care to encourage their development within the States.
- # Develop a working definition of recovery that can be used across systems, programs and stakeholder groups.
- # Provide education and technical assistance about recovery-oriented approaches to care.
- # Facilitate the development of an ethical framework for peer recovery support services, building on current standards.
- # Develop new financing models that will permit the treatment and recovery field to support recovery-oriented systems of care.
- # Continue to ensure that individuals and recovery organizations in recovery are represented in CSAT initiatives. Representatives should be diverse, reflecting a variety of recovery perspectives and personal characteristics such as race, gender, ethnicity and age.

“CSAT is planning to infuse recovery principles and measures into our policies, programs, and products. We will also inform and support SAMHSA’s larger efforts to promote recovery by offering substance use disorder-related recovery ideas that can be incorporated into the larger behavioral health picture.”

Recommended Next Steps for Consideration by Systems Professionals

- # Encourage National Association of State Alcohol/Drug Abuse Directors (NASADAD) to convene, educate and support Single State Authorities (SSAs) in the development of recovery-oriented systems of care.
 - # Utilize regional meetings as a venue for sharing information on the challenges and opportunities for designing and implementing recovery-oriented systems of care.
 - # Create opportunities at the State level for dialogue among key stakeholders such as treatment and recovery support service providers. Support stakeholders in promoting and disseminating a shared vision, clear messages and a collaborative action plan.
 - # Inventory current programs and practices in the States to determine strengths and gaps from a recovery-oriented perspective, including experience, opportunities and challenges in working with nontraditional providers of recovery support and with allies and partners from other systems.
 - # Invest in building capacity where needed.
 - # Expand and strengthen collaborative and integrative work with other systems—from mutual aid organizations to criminal justice systems—that serve the needs of individuals, families and communities seeking recovery.
-

“We need to function as change agents, convening key stakeholders at the State level to promote dialogue. We need to replicate at the State level what is happening here at the Summit – engaging people from across the treatment and recovery field and, where necessary, remediating perceived differences and finding common ground where everybody can both contribute and gain.”

–A Summit Participant

Recommended Next Steps for Consideration by Treatment Providers

- # Participate with other stakeholders in all aspects of design, planning and implementation of recovery-oriented systems of care, starting with the recommended regional summits on recovery-oriented systems of care to be convened by CSAT.
- # Engage and involve professional associations and public opinion leaders in the effort to develop recovery-oriented systems of care.
- # Work with recovery support service providers to clarify role definition, with a vision to

create a seamless relationship on behalf of the person served.

- # Further integrate the Guiding Principles of Recovery and Elements of Recovery-Oriented Systems of Care into clinical frameworks.
- # Survey treatment providers to identify strengths and gaps and promising practices from a recovery perspective, including experience, opportunities and challenges in working with nontraditional providers of recovery support and with allies and partners from other systems.
- # Explore innovative funding strategies to support recovery-oriented systems of care.
- # Offer a full range of recovery options that begin in treatment and continue beyond the treatment episode.
- # Provide outreach to engage individuals in treatment and continuing recovery support as part of recovery-oriented systems of care.

“As clinicians, we need to think about the clinical implications of broad recovery principles and how they apply to specific populations such as women or people with co-occurring conditions. We also need to consider the clinical implications of addressing recovery issues across the life span, and within multigenerational contexts.”

—A Summit Participant

Recommended Next Steps for Consideration by Recovery Support Service Providers

- # Clearly differentiate recovery support services from treatment and mutual aid programs, seeking, in both cases, to expand and enhance existing systems of care.
- # Identify and disseminate promising trends and best practices in recovery support services.
- # Collaborate with evaluators and researchers to develop research partnerships that integrate the perspectives and experiences of recovering people to develop programs and services within recovery.
- # Continue to build the capacity of recovery communities and recovery community organizations to provide peer recovery support services.
- # Improve internal capacities to provide accountability, including financial management, corporate governance and data collection for measuring results.
- # Help to close gaps between systems and cultures, bringing the authentic voice of diverse recovery communities to the tables where decisions are made, and providing technical assistance to new recovery support service providers.
- # Develop diverse funding strategies that will sustain recovery support services.

“Recovery support services are social vehicles for recovery. These nonclinical services often operate to initiate or support recovery in conjunction with the work of formal treatment or mutual aid groups.”

–A Summit Participant

Recommended Next Steps for Consideration by Researchers and Evaluators

- # Form partnerships between members of the recovery community and researchers to enrich and broaden the scope and content of research and develop instruments specifically designed to measure recovery outcomes.
 - # Create and support a research agenda on recovery (e.g., studies on multiple recovery processes, alternative methods of information collection and recovery-oriented outcome measures).
 - # Convene a research summit on recovery to promote knowledge exchange and increase awareness of projects under development within the research community.
 - # Publish and disseminate recovery-based research.
 - # Assist the treatment and recovery field in translating research findings into policy and practice.
-

“We need to conceptualize recovery research across all recovery stages and pathways to form an integrated research agenda. Alternative methods of information collection should include participatory action research. Research questions and measures of recovery should be strength-based and gender-specific and include expanded definitions of family. We need to develop longitudinal models to determine predictors of sustained recovery and long-term outcomes.”

–A Summit Participant

Recommended Next Steps for Consideration by Mutual Aid Organizations

- # Convene a meeting of mutual aid representatives to foster dialogue and collaboration.
- # Write a concept brief on mutual aid, covering its history, strengths and limitations, including ideas for how this stakeholder group can best contribute to recovery-oriented systems of care without compromising its unique qualities and value.
- # Develop a strategy for dissemination of information on mutual aid groups and approaches.

- # Create a self-assessment instrument to help people in or seeking recovery choose from the full menu of available mutual aid programs and other recovery support services.
- # Create a comprehensive Web site that provides educational information on mutual aid groups and links to their contact information.
- # Using existing processes and structures, participate with other stakeholder groups in the continuing development of recovery-oriented systems of care.

A mutual aid self-assessment tool would be valuable to people in early recovery who want to determine which system fits best with their needs and values. This is particularly important for people with histories of trauma, mental illness or incarceration who may need an alternative or adjunct to traditional 12-Step programs.”

–*A Summit Participant*

Recommended Next Steps for Consideration by Recovery Advocates

- # Promote education, feedback and buy-in among recovery advocates on recovery-oriented systems of care.
- # Organize and build capacity within recovery communities and recovery organizations to promote the strength of those in recovery as both an advocacy strategy and a message of hope to those who need it.
- # Ensure that individuals in recovery have authentic representation and input into policy and systems development and before local, State and Federal funding bodies. Actively recruit, develop and support leaders to articulate concerns to policymakers.
- # Ensure that people who are currently receiving or seeking access to treatment have an authentic voice in policy and systems advocacy efforts.
- # Destigmatize individuals with substance use problems and people in recovery through campaigns to raise public awareness, confront discrimination and address barriers to recovery, especially for ex-offenders.
- # Continue to develop relationships with recovery communities, and recovery community organizations, researchers, funders and local, State and Federal policymakers.
- # Strengthen the community web of support for recovery, including engaging individuals with long-term recovery who can help anchor recovery-oriented systems of care in the history of the field.

“It is important to ensure that organized recovery communities have authentic representation and input in all recovery-oriented systems of care. This will entail creating a ladder for leadership development and support that begins at the grassroots level. Bringing these voices of authentic recovery to the table will help guide the community in making sound decisions.”

–A Summit Participant

The National Summit on Recovery provided a forum through which expert stakeholders including individuals in recovery, family members, representatives of mutual aid groups, treatment providers and systems professionals engaged in dialogue and consensus building. Through the Summit they developed broad, generally applicable principles of recovery and identified elements of recovery-oriented systems of care. This report represents the first comprehensive document on this topic that incorporates the views of a diverse group of stakeholders. It is intended as a starting point for future dialogue, planning, and implementation on the national, State and local levels.

“When people from the treatment and recovery communities come together to share their best thinking and their passion, real growth can come from it. When the subject is recovery, that something has the potential to be transformative.”

*–George Gilbert, Director
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Appendix 2: Summit Agendas

**Appendix 2.1: CSAT National Summit on Recovery
Planning Group Meeting Agenda**

**Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment**

**June 13 and 14, 2005
Rockville, MD 20857**

Agenda

Monday, June 13, 2005

- 9:00 a.m. – 9:15 a.m. Welcome and Introductions
- Catherine D. Nugent, M.S., M.S., LGPC
Senior Public Health Advisor/Project Officer
Recovery Community Services Program
Center for Substance Abuse Treatment (CSAT)
Substance Abuse and Mental Health Services Administration
(SAMHSA)
Rockville, Maryland
- 9:15 a.m. – 9:30 a.m. The Charge
- George R. Gilbert
Director
Office of Program Analysis and Coordination
CSAT/SAMHSA
Rockville, Maryland
- 9:30 a.m. – 9:45 a.m. Meeting Outcomes and Processes
- Susan Hailman
Director
Knowledge Transfer and Utilization
Campaign Consultation, Inc.
Baltimore, Maryland
- Paul Harris
Project Specialist
Campaign Consultation, Inc.
Baltimore, Maryland

Monday, June 13 (Continued)

9:45 a.m. – 10:10 a.m. Perspectives from the Field: Building on What We Know

June Gertig
Senior Associate
Health Systems Research, Inc.
Washington, D.C.

Melanie Whitter
Senior Associate
Abt Associates, Inc.
Bethesda, Maryland

10:10 a.m. – 10:30 a.m. BREAK

10:30 a.m. – 12:30 p.m. Facilitated Discussion

Susan Hailman
Paul Harris

12:30 p.m. – 1:45 p.m. Working Lunch

Panel: Related Recovery Initiatives

Moderator

Stephen Wing, M.S.W.
Associate Administrator for Alcohol Policy
Office of Policy and Program Coordination
SAMHSA
Rockville, Maryland

Panelists

Paolo DeVecchio
Associate Director for Consumers Affairs
Center for Mental Health Services
SAMHSA
Rockville, Maryland

Dona M. Dmitrovic
Director
Center for Education and Advocacy
Johnson Institute
Washington, D.C.

Monday, June 13 (Continued)

Stacia Murphy
Director
National Council on Alcoholism and Drug Dependence
New York, New York

Pat Taylor
Campaign Coordinator
Faces and Voices of Recovery (FAVOR)
Washington, D.C.

1:45 p.m. – 2:10 p.m. Measuring Recovery – SAMHSA’s National Outcome Measures

Mady Chalk, Ph.D.
Director
Division of Services Improvement
CSAT/SAMHSA
Rockville, Maryland

2:10 p.m – 2:30 p.m. BREAK

2:30 p.m. – 5:00 p.m. Themes and Issues: Highlighting Topics That Resonate

5:00 p.m. CLOSING

7:30 p.m. Optional Evening Networking Session

Tuesday, June 14, 2005

8:30 a.m. – 9:00 a.m. Opening/Framing the Day

9:00 a.m. – 9:10 a.m. Logistics for the Summit

Donna M. Cotter, M.B.A.
Public Health Advisor
Office of Program Analysis and Coordination
CSAT/SAMHSA
Rockville, Maryland

9:10 a.m. – 10:15 a.m. Framing the Questions for the Summit: Principles and Measures

Susan Hailman
Paul Harris

10:15 a.m. – 10:45 a.m.

BREAK

10:45 a.m. – 12:00 p.m.

Framing the Questions for the Summit: System of Care

12:00 p.m. – 12:15 p.m.

CLOSING

Catherine D. Nugent, M.S., M.S., LGPC

Appendix 2.2: CSAT National Summit on Recovery Agenda

**Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment**

**September 28 and 29, 2005
Washington, D.C.**

Agenda

Anticipated Outcomes

CSAT Summit participants will:

1. Develop new ideas to help transform policy, services, and systems toward a recovery-oriented paradigm that is more responsive to the needs of people in or seeking recovery, as well as their family members/significant others.
2. Articulate principles and measures of recovery that can 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 in various settings and systems (e.g., criminal justice, faith communities, peer support programs, etc.), and for specific populations (e.g., racial and cultural groups, women, persons in medication-assisted recovery persons with co-occurring disorders, etc.)

Wednesday, September 28, 2005

Part I: A View of Yesterday and Today

9:00 a.m. – 9:30 a.m. Welcome – Washington Room, Roof Level

Charles G. Curie, M.A., ACSW
Administrator
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services
Rockville, Maryland

9:30 a.m. – 10:00 a.m. Introductions

Catherine D. Nugent, M.S., M.S., LGPC
Senior Public Health Advisor
Center for Substance Abuse Treatment (CSAT)
Substance Abuse and Mental Health Services Administration (SAMHSA)
Rockville, Maryland

10:00 a.m. – 10:20 a.m. Vision and Purpose of Summit

H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM
Director
CSAT/SAMHSA
Rockville, Maryland

10:20 a.m. – 10:45 a.m. Break

10:45 a.m. – 12:00 p.m. Guided Tour through the History of Recovery

Activity to depict and honor the history of recovery. We will identify where our own histories intersect with the history of treatment and recovery, and explore the strengths and limitations of systems of care for people in recovery throughout the decades.

Facilitators: Susan Hailman
Director
Knowledge Transfer and Utilization
Campaign Consultation, Inc.
Baltimore, Maryland

Paul Harris
Project Specialist
Campaign Consultation, Inc.
Baltimore, Maryland

Tom Hill
Technical Assistance Manager
Recovery Community Services Program
Technical Assistance Project
Health Systems Research, Inc.
Washington, D.C.

Special Guest Moderator: Stacia Murphy
Director
National Council on Alcoholism
and Drug Dependence (NCADD)
New York, New York

Part II: Moving Forward

1:30 p.m. – 3:30 p.m. **Principles and Measures of Recovery** – See sheet entitled Break-Out Session Information for Room Locations

Participants will meet in small groups to develop principles and measures of recovery from various perspectives.

- 3:30 p.m. – 4:00 p.m. Break
- 4:00 p.m. – 5:15 p.m. **Plenary Session: Speakout** – Washington Room, Roof Level
- Participants will be invited to share insights and ideas generated from the discussion to inspire transformation of systems of care for people in recovery and their family members.*
- 5:15 p.m. – 5:30 p.m. **Summary and Closure**
- 6:00 p.m. – 7:00 p.m. **Optional Recovery Support Meetings**
- AA – Parkview, Lobby Level
- NA – Federal Room, Mezzanine Level
- Al-Anon – Caucus Room, Mezzanine Level
- Smart Recovery – Board Room, Mezzanine Level
- 8:00 p.m. **Optional Networking Event** – Washington Room, Roof Level

Thursday, September 29, 2005

Part III: Integrating Change into Systems of Care

- 8:30 a.m. – 9:30 a.m. **Panel Presentation: Voices from the Field** – Washington Room, Roof Level
- Brief Report on Adolescent Focus Groups
Randolph Muck, M.Ed.
Team Leader, Adolescent Programs
CSAT/SAMHSA
Rockville, Maryland
- Brief Report on RCSP Grantees’ Discussion of
Peer Recovery Support Services
Philip Valentine
Executive Director
Connecticut Community for Addiction Recovery
Wethersfield, Connecticut
- Brief Report on FAVOR Recovery Advocacy Summit
Pat Taylor
Campaign Coordinator

Faces and Voices of Recovery (FAVOR)
Washington, D.C.
Respondent:
William White
Senior Research Coordinator
Chestnut Health Systems
Bloomington, Illinois

Moderator: Susan Hailman

9:30 a.m. – 10:30 a.m. **The Future Vision: What Could a Recovery-Oriented System of Care Look Like**

Small group discussion among the various sectors represented at the Summit.

10:30 a.m. – 11:00 a.m. Break

11:00 a.m. – 12:00 p.m. **Weaving the Vision**

Discussion of recovery-oriented system of care continues in mixed sector groups.

12:00 p.m. – 1:00 p.m. Lunch

1:00 p.m. – 2:00 p.m. **Strategies for the Future** – See sheet entitled Break-Out Session Information for Room Locations

Sector groups reconvene to develop strategies through which each sector could stimulate the development of a recovery-centered system of care.

Appendix 2.3: CSAT Follow-up Meeting Agenda

**Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment**

**December 14 and 15, 2005
Washington, D.C.**

Agenda

Anticipated Outcomes

CSAT Recovery Summit Follow-up Meeting participants will:

1. Develop a working definition of recovery.
2. Review and refine principles of recovery and elements of a recovery-oriented system of care.
3. Identify other stakeholders who need to become supporters.
4. Define actions to be taken by CSAT based on Summit results.
5. Develop sector action plans based on Summit results.

Thursday, December 14, 2005

9:00 a.m. – 9:20 a.m. Opening and Welcome

George R. Gilbert
Acting Deputy Director
CSAT/SAMHSA

9:20 a.m. – 9:30 a.m. Agenda and Material Review

Facilitators:
Susan Hailman
Director
Knowledge Transfer and Utilization
Campaign Consultation, Inc.

Paul Harris
Project Specialist
Campaign Consultation, Inc.

9:30 a.m. – 10:30 a.m. Defining Recovery (Part 1):

The group will develop a working definition of recovery.

10:30 a.m. – 10:45 a.m.	Break
10:45 a.m. – 12:15 p.m.	Principles of Recovery and Elements of a Recovery-Oriented System <i>The group will examine and refine the Summit's work on principles of recovery and elements of a recovery-oriented system.</i>
12:15 p.m. – 1:30 p.m.	Lunch (on your own)
1:30 p.m. – 2:30 p.m.	CSAT Recommendations and Actions <i>The group will hear a review of the recommendations for CSAT that emerged from the Summit.</i> Donna M. Cotter, M.B.A. Partners for Recovery Coordinator CSAT/SAMHSA
2:30 p.m. – 2:45 p.m.	Break
2:45 p.m. – 4:45 p.m.	Sector Review <i>The group will break into sectors to review, consolidate, revise, and prioritize recommendations for their sector.</i>
4:45 p.m. – 5:00 p.m.	Wrap-Up of Day 1
5:00 p.m.	Adjourn

Friday, December 15, 2005

9:00 a.m. – 9:30 a.m.	Day 2 Opening – Reflections
9:30 a.m. – 10:30 a.m.	Sector Recommendations Review and Comments <i>The group will review recommendations of all sectors.</i>
10:30 a.m. – 10:45 a.m.	Break
10:45 a.m. – 12:00 p.m.	Potential Partners and Venues for Dissemination <i>The group will identify potential partners and opportunities to persuade and educate the field regarding the preliminary findings from the Summit.</i>
12:00 p.m. – 1:15 p.m.	Lunch (on your own)

1:15 p.m. – 2:30 p.m.

Sector Response (Part 1)

The group will explore potential responses to existing opportunities by sector.

2:30 p.m. – 3:30 p.m.

Sector Breakouts

Each sector will meet to create a basic action plan integrating the ideas developed in the above discussions to present back to the group.

3:30 p.m. – 4:45 p.m.

Defining Recovery (Part 2):

The group will return to the definition of recovery to summarize what has been offered and make any recommendations of products, publications, or actions that could result.

4:45 p.m. – 5:00 p.m.

Closing

Catherine D. Nugent, M.S., M.S., LGPC
Senior Public Health Advisor
CSAT/SAMHSA

Appendix 3: Background Paper—Recovery Themes

Background Paper—Recovery Themes

Introduction

This paper has been prepared as part of the background material for the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) planning group which will meet on June 13–14, 2005, to prepare for a CSAT National Recovery Summit scheduled for September 28–29, 2005. The Recovery Summit will gather approximately 100 leaders from the addiction treatment and recovery communities who will seek to:

1. Reach a shared understanding of principles of recovery from addiction¹ to alcohol and/or other drugs,
2. Identify domains and associated markers that lend themselves to measuring recovery, and
3. Recommend next steps for moving addiction treatment systems beyond a pathology-based focus on the remission of symptoms to a focus on wellness.

The purpose of this paper is to assist the planning group in its considerations of how best to facilitate the National Recovery Summit's achievement of the first goal—a shared understanding of principles of recovery.²

A substantial body of clinical and research literature exists on addiction, pretreatment and treatment activities, relapse prevention, and early recovery (the stage most often measured in treatment outcome studies). Considerably less can be found on middle-stage and ongoing recovery. However, a large body of literature, prepared by individuals in recovery and members of mutual aid groups, lays out experientially derived processes and methods for achieving and sustaining recovery.

In addition, numerous perspectives on addiction recovery and treatment models for medically assisted recovery have been advanced by leaders in a wide array of professions—ranging from clinicians and social workers to brain researchers and other scientists. Much information, particularly about early recovery, has been generated by treatment practitioners, evaluators, and systems professionals. Also, researchers are beginning to accumulate information about successful recovery strategies that involve neither formal treatment nor mutual aid support.

The perspectives and models of recovery presented in professional and lay literature have emerged from a wide variety of social, cultural, and life cycle contexts and represent many different voices. Multiple voices and perspectives do not lend themselves easily to the development of shared definitions or a unified theory. Yet, in practice, a pragmatic streak of eclecticism exists, with peers, practitioners, researchers, and theoreticians frequently drawing from what appear to be promising practices and wisdom representing various doctrines, methods, and styles of recovery.

The authors have also adopted an eclectic approach in preparing this background paper on recovery. Such an approach is consistent with a major theme that emerges from the literature: Like addiction, recovery is a complex and dynamic process. Race, class, ethnicity, gender, sexual orientation, family history, life cycle stage, environment, and culture combine with the individual's

unique experiences, strengths, values, needs, and desires to form an ecological context within which recovery takes place. This means invariably that recovery is experienced differently by different people, depending on who they are and the circumstances and environment in which they live.³

Although no universally accepted definition of recovery exists, recovery can be understood to be a process of change that takes place between the individual and his or her relationship to alcohol and/or other drugs, which typically is experienced in many dimensions of life.⁴ This understanding forms the basis for this paper, which is presented in three sections. Section 1, The Architecture of Change, identifies a number of themes that occur in the literature relating to the nature of change during the recovery process. Section 2, Recovery Across Body, Mind, Relationships, and Spirit, is an in-depth exploration of one overarching theme that emerges from the literature—the holistic nature of physical, mental, social, and spiritual changes experienced by an individual throughout recovery. The paper concludes by highlighting some of the tensions and unresolved issues that exist in any discussion of themes on recovery in Section 3, Illustrative Questions for Discussion and Dialogue.

Themes found in the literature are not principles of recovery themselves, but they can inform the search for principles in several ways. In some cases, a theme may point the way to a clear consensus on a matter that likely will be widely accepted as a shared principle without much discussion. In other cases, themes can reveal tensions between and among differing viewpoints. In these cases, discussion and dialogue can help to bridge the gap between views, honoring the truth of each in the development of shared principles. Alternatively, discussion and dialogue can shed new light on hard questions, moving the addiction and recovery field forward in its thinking. This paper is presented in the spirit of advancing such a discussion and dialogue.

Section 1: The Architecture of Change

This section is a distillation of a number of themes from the literature relating to the nature of change in the recovery process. These themes reflect many varieties of individual experience and at times display seemingly contradictory qualities or phases. These contradictions are often reconciled over time. Therefore, respect for differences and an appreciation for paradox are needed in the search for shared principles of recovery.

Many Ecologies of Change. Each individual lives within an ecological system that is composed of personal, social, cultural, and environmental factors and influences. The base of this constellation of factors lies in one's origins (e.g., family, race, ethnicity, gender), upon which are superimposed current realities of status (e.g., economic, educational, health, criminal justice, mental health), quality of "place" (e.g., where one lives, works, and finds community), and belief and value systems. These factors and influences can be major determinants of the individual's threshold for change and, depending on their context, can function as either bridges or barriers to recovery. One way to view the ecology of change for a given individual is to look at his or her recovery capital, a concept first introduced by Granfield and Cloud which refers to the sum total of social, psychological, and human capital that can be drawn upon for support.

Many Pathways of Change. The variety of recovery experience reflects the complex dimensions of function affected as well as the unique strengths, values, needs, and desires that each recovering person brings to the process. As White notes, the expanding varieties of recovery experience are reflected in the growing diversity of mutual aid groups, the proliferation of religious and cultural frameworks for recovery, the growth of medically assisted recovery, and increasing recognition of natural recovery.

Holistic Change. People from many varieties of recovery experience have a shared understanding that initiating and maintaining a changed relationship with alcohol and/or other drugs is not a simple matter of making a single change in behavior. Rather, it is a holistic process involving many of life's domains—one's physical self (including the brain); how one thinks and processes emotions and feelings; one's relationships; and, for many, one's spiritual life. Each of these domains is addressed more fully in Section 2 of this paper.

Incremental/Transformative Change. People experience and/or analyze the recovery process in different ways. Some describe their recovery as occurring in small, incremental steps while others experience it as transformative, with major changes occurring suddenly. Often, it is portrayed as both. In 12-Step programs, for example, the newcomer is cautioned to take it "one day at a time" but also learns that "the promises," with their vision of a transformed self, will come into being over time. A strong subtheme is the concept of identity transformation, with important variations thought to exist along gender, cultural, and life cycle parameters. With respect to identity, debate exists about the positives and negatives of accepting the label of alcoholic or addict. Identity transformation often is linked closely to the power of shared story, which is often a major strategy for recovery initiation and maintenance.

Nonlinear Change. Like other changes in life, recovery is not a linear process; it is often depicted graphically as a spiral, with movement in both directions on the spiral. Although the field has no shared definition of relapse, a number of models and strategies, such as those put forth by Marlatt and Gorski, exist for preventing it and for minimizing the consequences when relapse occurs. Relapse also has been viewed as a learning opportunity in the context of managing a chronic condition, as McLellan and others have pointed out. As a practical matter, however, a person who relapses may find his or her access to treatment and other recovery support services terminated and also may feel shamed within his or her mutual aid community.

Developmental Model of Change. A person who is one day sober is not in the same place as a person with 30 days, 1 year, or 10 years of sobriety. This reflects the number and degree of changes that take place over time in various aspects of the recovering person's life and continued human development. A number of thinkers, including Larsen, Brown, DiClemente, and Picucci, have developed various staged or developmental models of recovery to describe this process. Among these models, the stages of change model has been researched most thoroughly and is well known in the treatment world, though less so in the recovery community. These models reflect a sense that despite the multiple pathways, dimensions, and zigzags that characterize the many types of recovery experience, recovery generally follows predictable stages. These stages are marked by common milestones and seen as opportunities to build on changes that occurred in earlier stages in the process. Moving to a new stage has inherent risks, especially when people are asked to accomplish goals that they may not be ready for. The existence of numerous models of human

development across the life span should be noted. Where any given person is in the life cycle—e.g., adolescence; early, middle, or late adulthood; old age—will affect his or her recovery process.

Safety as a Foundation for Change. The need to feel safe in the recovery process underlies the various structures of confidentiality and anonymity that pervade formal and informal treatment and recovery support systems. In recent years, this theme has acquired broader significance within the context of the early recovery needs of people who are survivors of violence and/or trauma, homeless, or living in unsafe environments.

Motivation: Pain and Hope as Foundations for Change. Most peer and professional recovery support approaches agree that motivation plays a central role in recovery. According to traditional 12-Step and treatment thinking, the motivation to change emerges from the pain of “hitting bottom.” Pain often increases, and motivation may be enhanced, when others stop enabling the individual or when one’s family and associates conduct an intervention. More recently, among increasingly disempowered persons as well as those with co-occurring disorders, the opportunity to take part in empowering activities has been identified as a necessary precursor to the development of motivation. What is needed before some persons can develop the motivation to initiate recovery is not more pain but hope.

Power and Powerlessness in the Change Process. One of the many paradoxes for persons in recovery is the need to strike a delicate balance between, on the one hand, accepting that one is powerless over alcohol and drugs and, on the other, developing the strength needed to overcome addiction. In the context of Alcoholics Anonymous, its offshoots, and many faith-based approaches to recovery, resolving this paradox requires surrender to a Higher Power. There is a great body of literature, most notably by Tiebout and Kurtz, on the psychological and spiritual significance of surrender and admission of powerlessness.

As noted by Williams, Kasl, Covington, and Kirkpatrick, some groups of people in recovery, including many women and Americans of color who see themselves as oppressed and disempowered, perceive the admission of powerlessness and surrender as a further undermining of their hope for recovery. In order to achieve recovery, many of them—as well as others who have resisted either the admission of powerlessness or the spiritual aspects of surrender—have taken the opposite route: laying claim to power. Thus, some people gain control over the use of substances, not by accepting notions of their powerlessness but by devoting energies to establishing their own internal power. Through this process, they develop the resilience and self-esteem needed to implement and sustain recovery. Countless millions of people in recovery around the world have embraced one or the other of these notions, sometimes (but not always) rejecting the other. Many have integrated both.

Intentionality and Choice in the Change Process. Intentionality means choosing to undertake the hard work of recovery by taking personal responsibility to safeguard and protect one’s own recovery despite the many perceived obstacles ahead. For most people, recovery is an intentional process, with the individual playing an active role in initiating and, eventually, sustaining recovery within a web of self-selected supports that include a sense of place, community, and relationships with others. Intentionality assumes that the individual is ready, willing, and able to make these choices.

Paradoxically, the process of recovery often begins at a place where the individual, in fact, may be faced with limited choices and limited confidence in his or her ability to make those choices. The constriction of choice can take many forms: external pressures that oppose continued use of drugs and/or alcohol, such as the threat of imprisonment and correctional sanctions or fears of job loss, child-welfare pressures, family or community norms that may oppose or support continued use, lack of meaningful or personally acceptable treatment or recovery support options, and hopelessness, to name just a few.

Section 2: Recovery Across Body, Mind, Relationships, and Spirit

Both the literature and the practices of people seeking to achieve or sustain recovery clearly demonstrate that recovery is a process of change that involves the whole person, with all of his or her strengths, weaknesses, desires, goals, and values. Physical changes in the body (including the brain) are coupled, in the mind, with changes in thinking patterns and acquiring new methods of dealing with emotions. Change also commonly occurs in a person's relationships with other people and his or her community. For many people, the process of change in recovery has a strong spiritual component.

These four domains of holistic health—body, mind, relationships, and spirit—parallel the biopsychosocial model of addiction. These domains are interactive, and change in one can influence change in another. Each is a place where recovery can begin and where recovery can be either strengthened or stymied. Different recovering individuals assess and balance the various changes differently, based on individual needs and preferences and the personal ecology in which recovery occurs, all of which change over time as recovery progresses.

A. Body

Brain and Central Nervous System. Researchers for the National Institute on Drug Abuse (NIDA) and in research centers around the world increasingly see addiction as a complex and chronic brain disorder that cannot be isolated from its behavioral and social components. Like Alzheimer's, Parkinson's, schizophrenia, and depression, addiction has behavioral and social dimensions. Research is yielding medical avenues to help assist recovery for some individuals. In early recovery, individuals often face a number of problems centered in the brain, such as detoxification, cravings, the response to events and environmental conditions that trigger cravings, and the reestablishment of brain and central nervous system functions affected by addiction. The confusion and befuddlement of very early recovery can fade away, but some brain effects are thought to be long lasting and may persist throughout recovery. Individuals with co-occurring mental and addictive disorders may experience change related to each disorder.

Physical Health. Individuals in early recovery often become concerned with their general health, which may have been neglected, sometimes for many years. Common problems include liver disease, anemia, and other nutritional deficiencies resulting from poor dietary habits, neuropathy, HIV infection, hepatitis C, herpes, and sexually transmitted and other infectious diseases, including tuberculosis. Dental problems also are common. For those who have been living in the cramped and crowded conditions of shelters, jails, or prisons, multiple-drug-resistant tuberculosis and other

infectious diseases can be a major problem, not just for the individuals directly affected but also for the communities to which they return.

Ideally, these conditions are identified early in recovery through a physical examination. Feelings of shame and a desire to avoid disapproval may prevent many from disclosing their addictive and recovery status to the physician or other health care provider. This is unfortunate, because full disclosure of past addiction history is necessary in order for the health care provider to recommend appropriate diagnostic tests and to help minimize the adverse health conditions that often accompany addiction. Sometimes, medical problems emerge in later stages of recovery. Hepatitis C, in particular, is often discovered only after an individual is well along in recovery.

The presence of disorders that cause chronic or acute pain can present a significant challenge to the person in recovery, because many pain-killing medications contain mood-altering drugs. This may be a particular challenge for individuals who have been addicted to opiates such as heroin and who are now drug free. For example, practitioners unfamiliar with the recovering person's history might provide opiates or opioid medication for acute pain, unwittingly triggering relapse.

It is a good idea for a recovering person to work closely with a pain management specialist who is knowledgeable about addiction and who can consider nonpsychoactive medications and techniques for pain control. If psychoactive medications become necessary, the pain management specialist can establish baseline dosages, carefully titrate the medication, and cautiously manage the patient's medication needs while assisting with maintaining recovery.

Individuals who have been addicted to opiates and who utilize an opioid-based form of recovery assistance, such as methadone, may also have acute or chronic pain issues. Nonpsychoactive medications may be effective for pain control, but opioid-based medication may become necessary in some cases. One common myth about patients in medication-assisted treatment is that these patients do not experience pain or cannot benefit from opioid-based pain medication. It is a good idea for these patients to work with both their opioid treatment physicians and a pain management specialist to control pain while maintaining gains made in recovery.

As recovery progresses, many people become involved in a proactive health regimen that includes healthy eating, exercise, and rest. Many recovering individuals find alternative health interventions, ranging from brain wave biofeedback to yoga and acupuncture, helpful in sustaining long-term recovery.

B. The Mind

At a minimum, the person in early recovery has to learn how to overcome the strong cravings common in early recovery and how to identify and avoid the triggers that can prompt relapse. He or she will need to accomplish the challenging task of learning to identify the cycle of environmental cues, thoughts, emotions, and behaviors that act as triggers, and develop coping strategies. This task must be undertaken during a period which is frequently emotionally turbulent. Painful feelings associated with acknowledging the harm one may have done to others or suffered at the hands of others can be particularly strong, especially when powerful cravings are present, and the person in recovery will need to develop new strategies to cope with these powerful feelings as well.

Many people discover hidden strengths and resilience as they face these challenges. Some discover problem-solving skills (including insight and resourcefulness) or a sense of purpose and future (such as goal-directedness and an innate optimism and persistence). Others may have strong social competencies (such as good communication skills or a sense of humor) that will make it easier for them to find allies to support them. Many others may need support in building these skill sets.

The person in early recovery can be helped by many strategies and techniques for learning new behaviors. Cognitive restructuring can be achieved in numerous ways, including cognitive behavioral therapy (CBT), social skills training, and participation in the rituals and processes of mutual aid groups. Other key components in sustaining one's recovery are learning to identify personal stressors; developing a personal approach to stress management, self-care, and self-efficacy; and practicing these skills each day.

Other common and important tasks during early stages of recovery are addressing powerful feelings of grief, loss, shame, and guilt about the past, and facing one's fears and apprehensions about the future. When these feelings are not dealt with, they can linger, adversely affecting relationships and self-esteem as well as hampering the ability to accomplish the tasks of daily life and develop or regain a sense of competence. A strong sense of competence helps to facilitate the development of effective cognitive processes and increases performance in a variety of areas of life.

Another important task of ongoing recovery is to develop a healthy sense of autonomy in order to establish and maintain personal boundaries and establish healthy relationships. Learning to resolve the tension between the desire for closeness and the need to establish appropriate distance is necessary for preserving personal relationships and establishing and maintaining new ones. For some, this can include cultivating quality nonsexual relationships with persons of the opposite gender, perhaps for the first time in their lives.

As recovery continues to progress, priorities often shift to achieving important but less urgent goals. This change in focus may come about naturally, as confidence in one's ability to sustain recovery grows. Educational or career development goals may emerge, as well as a desire to address unresolved family issues.

C. Intimate and Social Relationships

The task of building a network of social support is perhaps the most challenging part of recovery work. At the center of the web is a person in early recovery whose own sense of self-worth may be fragile and who may be overwhelmed by demands to reprocess and sometimes reconfigure the internal dynamics related to his or her most important relationships. He or she may have many or few social skills and healthy relationships to fall back upon. As one moves out from the center to family and other intimate relationships, peers, community, and culture, he or she will find many resources that support recovery. At the same time, the individual will encounter others that undermine recovery and will be put to the task of distinguishing between them and deciding which fit comfortably with his or her newly recovering self.

Reconnecting with and sometimes disconnecting from friends, acquaintances, and colleagues are important goals. Decisions about reconnecting and coming to terms with necessary separations constitute challenges, because bonds of love and deep human needs are often involved. For the same reasons, cultivating strong and healthy new relationships is rewarding and contributes to a recovery that endures. One mark of mature recovery is completion of these processes.

Family and Other Intimate Relationships. Some approaches to recovery focus on the family as a resource either to help initiate or support the individual's recovery process or to support the family's own needs for healing. For some individuals, family or other intimate relationships may have contributed to the development of addiction or may play a subversive role in recovery. In many cases, individuals will work to assess these relationships and will struggle at reestablishing or severing these important ties.

Assessing the current status of relationships and one's role within them can be emotionally charged. In the attempt to let go of relationships that are harmful, powerful feelings of grief and loss can occur. When attempting to reestablish former relationships, the individual often faces anger and resentment from others because of disappointments and hurts they experienced as a result of the individual's addictive behaviors. Recovering persons also often are challenged to "prove" that they are now responsible and trustworthy.

Sometimes work to heal the family as well as the recovering individual is done in an addiction treatment setting. Healing also may occur later in the recovery process, either with professional assistance (for those who can afford it) or with the help of peer support and advocacy groups. Sometimes it is done without any formal assistance.

Peers. Many people in early recovery shift from the self-imposed isolation of addiction to a desire for connection with other people. Assessing the current status of relationships with peers is often necessary. This frequently results in a severing of relationships with peers who are using substances. For many, mutual aid groups offer an opportunity to share their experience with others who are also restructuring relationships (or have already done so), observe social role modeling, take on responsibilities that enable them to develop skills, and learn from the sharing of stories with others. Mutual aid groups offer affiliation with, and an ability to contribute to, a community of peers who have shown demonstrable strength and even good humor in the face of adversity. The support from others provided in these groups can strengthen hope and a belief that recovery is achievable. However, some people in recovery do not participate in these groups, whether because they feel they do not need peer support; because the mutual aid groups available to them seem inconsistent with their values, life expectations, or worldview; or because they have poor social skills and difficulties interacting within a group.

Treatment Providers. Professional treatment providers can help the person in early recovery develop needed social and other life skills that contribute to effective socialization. However, treatment episodes are often brief and focus primarily on the task of stabilization. Continuing care and emerging techniques (such as posttreatment brief telephone "check-ins") can sometimes extend the ability of the treatment provider to play this supportive role during early recovery. Of course, many people cannot or do not avail themselves of treatment opportunities.

Community and Culture. The recovering person and his or her network of family, professional, and peer supports are nested within the larger community. This community may provide supports that nurture recovery, as well as conditions that foster relapse. At a minimum, the recovering person is likely to encounter stigma and discrimination in the community. Persons with co-occurring conditions (e.g., mental disorders) or characteristics (e.g., ex-offender status) often struggle with compounded stigma and discrimination.

Sometimes people look to the strengths of their culture as a source of support for recovery. For example, for Native Americans, *The Red Road to Wellbriety: In the Native American Way* integrates the wisdom of elders, traditional values, healing practices as depicted on the Medicine Wheel, and the insights of 12-Step fellowships within a community-based recovery support system. Important political and cultural trends within the larger community—such as the civil rights and racial pride movements, feminism, and more recently the growth of Christian evangelism—are often reflected in recovery thinking as well. Typically, these cultural revitalization and social justice movements are concerned with healing the individual, the community, and society as a whole.

Life Tasks and Roles. Some persons in early recovery may need to learn new skills to survive in the larger society. They may need help in becoming employable, finding work, assuming the role of employee, finding suitable housing, and even acquiring basic skills such as learning how to prepare a meal. Many need to learn or relearn how to socialize without alcohol or other drugs as a social lubricant. Some will be challenged to develop a healthy sexual life that is not intimately connected to alcohol and/or drug use.

Liberated from their addiction, some individuals feel propelled to rediscover learning. Not only adolescents and young people but also older people whose education may have been interrupted by their substance use often return to school to complete their education and go on to pursue more advanced education and other professional goals. Others become interested in simply expanding their personal knowledge. Many take up expected family roles—son or daughter, spouse or partner, parent or grandparent—that they formerly ignored. Some do this within their prerecovery family structures, while others do so within new family arrangements or in other constructions of interpersonal relationships.

Success at an expanding array of life tasks and the assumption of new or enhanced roles in the community—as they are identified and defined by the person in recovery over time—both derive from and contribute to sustained recovery. Those without emotional and financial resources, social supports, or skills to accomplish new or enhanced tasks and roles may need a great deal of support from others to achieve their goals.

D. Spirit

Spirituality and spiritual development receive a great deal of attention in both lay and professional recovery literature. Many recovering persons, as well as researchers and clinicians, view spiritual development as a catalyst that can drive and give meaning to the changes in body, mind, and social relationships that characterize recovery. Many other recovering people, however, cannot accept what they see as a religious aspect of traditional approaches to recovery. In addition, the topic is

difficult to write about because it is personal in nature. Everyone “knows” what spirituality means, but it means different things to different people. Even so, one researcher, Ringwald, recently arrived at a definition that seems to embrace many other definitions: “[Spirituality is] an ongoing internal process of change that results in a transformation of the recovering person’s attitudes, values, beliefs, and practices.”

The traditional understanding about spirituality in addiction recovery, which comes from 12-Step fellowships, suggests that spiritual change begins when the person seeking recovery realizes that he or she is imperfect, cannot achieve recovery alone, and seeks help from an outside source. People taking the traditional spiritual route find that recovery can flourish through a connection to others; an affiliation with community; and a reliance on something greater than oneself, defined in a variety of ways, including “higher power” and God. Spiritually based programs give people in recovery a safe place to nurture the ongoing processes of healing, self-reflection, character building, and developing new attitudes and behaviors. A major component of spirituality is the ability to forgive and be forgiven for the range of things that went awry during addiction. The ethical principle of mutuality, or a spirit of “giving back,” also is associated with spiritual recovery approaches and functions as a support for one’s own recovery as well as the recovery of others.

Faith-based programs have brought new dimensions of spirituality into the recovery community. Increasing numbers of people are entering recovery through faith-based programs that are shaping new approaches to recovery by drawing directly from Judeo-Christian traditions in a way that publicly funded programs (where the majority of treatment has been provided in the United States) historically could not. These programs meet the person seeking recovery with the message that every human being is created in the image of God and is unconditionally loved by the creator. People entering the recovery community from these programs bring notions of God’s love as the empowering force that enables them to make the changes required to recover.

While 12-Step fellowships and faith-based organizations are the best-known venues for spiritual approaches to recovery, spirituality and cultural revitalization movements are often intertwined. For example, to help those who are not well served by non-Native treatment and recovery supports, the Native American community has embraced traditional spiritual healing and ceremonial practices including drumming, sweat lodges, talking circles, chanting, pipe ceremonies, smudging, and other rituals. In this tradition, true healing takes place within the context of the community, and the process of recovery is a quest for harmony and wholeness within the context of the self, the family, and the tribe.

Section 3: Illustrative Questions for Discussion and Dialogue

As is apparent in the foregoing sections of this paper, the literature on recovery reveals areas of both consensus and divergence. As the planning group moves forward with its design of the National Recovery Summit, it may want to look at some of the “hard questions” that are raised by the themes of recovery recounted in this paper, and consider how to address them in ways that promote agreement rather than discord. The following examples are suggestive and meant to assist the planning group by stimulating discussion related to the development of shared principles about recovery:

- # Some key concepts in recovery thinking are often expressed in ways that appear to be polar opposites. For example, some say that the key to recovery is admission of powerlessness; others say the key is empowerment. The pain and fear of negative consequences, on the one hand, are described as key motivators; on the other hand, hope and empowerment are described as the essential elements. How do we develop principles of recovery that recognize and reconcile such seemingly dichotomous perspectives?
- # In mental health recovery, as in many other areas of health, choice is seen as a fundamental driver of recovery, conferring dignity on the individual and underscoring his or her right to live a self-directed life. The freedom to make meaningful choices is seen as essential to the healing process. A person approaching recovery from addiction, on the other hand, is often doing so in a context where his or her past choices are seen as deeply flawed and his or her ability to make sound current choices is viewed with suspicion. Moreover, the person may be facing an enormous array of social and criminal sanctions if he or she doesn't comply with other people's judgment about what constitutes good choices. How do we develop a principle relating to choice that takes these realities into account?
- # Some Americans are attaining recovery via community- and culturally specific routes that focus first on healing the community (and sometimes the family). Does it represent fairly what we know about recovery—or what we hope to achieve by moving to a recovery-based paradigm—to develop recovery principles that are predominantly focused on the individual? If not, how could we expand the scope of these principles to include families and the community? How would these expanded parameters play out in our current systems?
- # Wellness-based models typically incorporate strength-based planning and notions of resilience. How do these constructs fit within a recovery paradigm?
- # Recovery is ultimately defined by most individuals as having a meaningful life that is consonant with their personal value system and includes values that derive from their religious and spiritual beliefs and their culture. How do we develop principles that acknowledge the power of these values?
- # It is commonly said that recovery is not a linear or one-step process—that there is important “prerecovery” work preceding a decision to initiate recovery and important continuing work after recovery has been established, and that relapse is a normal part of the process and can be a learning experience. What would a system look like that offered meaningful support at all stages, including prerecovery, continuing recovery, and relapse?

Notes

- ¹ As used in this paper, the term addiction includes alcoholism, and addict includes the alcoholic. These terms are widely used by people associated with different schools of thought, including those who reject disease-based concepts and terminology. The authors recognize and respect the preference of many to adopt less stigmatizing and more “person first” terminology, such as “persons with substance use disorders.”
- ² Materials related to Goals 2 and 3 also will be provided to assist the planning group.
- ³ A systematic exploration of the commonalities and differences in recovery thinking associated with the person (e.g., age, gender, sexual orientation, coexisting disorders and conditions) and his or her environment (e.g., culture, ethnicity, family, class, criminal justice involvement, housing status) is beyond the scope of this paper. Nevertheless, the importance of developing recovery principles that accommodate these differences cannot be overstated.
- ⁴ This change in relationship is defined in abstinence-based models as stopping all use. For those who approach the question from a disease perspective, diagnostic criteria may play a role in defining the changed relationship. DSM-IV, for example, provides diagnostic criteria for levels of substance use disorders. Based on these criteria, “Recovery from DSM-IV Alcohol Dependence: United States, 2001–2002,” a study released by the National Institute on Alcoholism and Alcohol Abuse in January 2005 based on data from the 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions, defined people as being in recovery if they were classified as being in partial remission, asymptomatic risk drinkers (who demonstrated a pattern of drinking that put them at risk of relapse), low-risk drinkers, or abstainers.

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Appendix 4: SAMHSA National Outcome Measures

National Outcome Measures (NOMs)

- Abstinence from Drug / Alcohol Use
- Employment / Education
- Crime and Criminal Justice
- Family and Living Conditions
- Access / Capacity
- Retention
- Social Connectedness
- Perception of Care
- Cost Effectiveness
- Use of Evidence-Based Practices

Appendix 5: Panel Presentation Summaries

Appendix 5.1: Phil Valentine: Recovery Community Services Program (RCSP)

Summary of Grantee Perspectives on Recovery from Discussion Groups at the August 2005 RCSP Annual Conference:

Recovery and the Whole Person

Principle 1

- Addiction can have its roots in any or all human aspects—physical, mental, social and spiritual.
- Successful recovery addresses and heals the physical, mental, social and spiritual aspects of a person.

Principle 2

- Addiction is a chronic disease and must be treated with the same integrity as other chronic diseases.
- Relapse is not an indication of noncompliance. It is a confirmation of the diagnosis.

Principle 3

- The recovery process of addressing wholeness is challenging and lifelong.

Principle 4

- Peer assistance is a natural bridge between leaving treatment and beginning a life of recovery in the world.
- Experienced peers are the best supports for those new in recovery.
- The system must recognize long-term recovery as a competency along with traditional clinical skills.
- Systems of care would:
 - Address recovery as a healing process focusing on the whole person—physical, mental, social and spiritual;
 - Require treatment facilities to elevate their “recovery-friendly” rating (as determined by the recovery community) to receive Federal and State funding;
 - Recognize recovery as a competency.

Recovery and Spirituality

- Spirituality is a key component in a high percentage of recoverees, but not all.
- Spirituality must be honored within a recovery-oriented system of care.
- Spirituality and religion should not be confused. Religion may be for some, but not for everyone.
- Spiritual journey transforms lives.

- Spiritual transformation facilitates movement from woundedness toward health, wholeness and ultimately wellness.

Recovery and Wellness

- Wellness could be defined as having healthy attitudes and behaviors concerning physical, mental, social and spiritual aspects.
- Wellness incorporates health holistically on individual, family and community levels.
- Wellness brings purpose and service.
- Recovery-oriented systems would increase opportunities for wellness through integration and networking.

Appendix 5.2: Pat Taylor: Faces & Voices of Recovery (FAVOR)

Faces & Voices of Recovery (FAVOR)

Faces & Voices of Recovery is working to mobilize, organize and rally the families, friends and allies of the millions of Americans in recovery from addiction in a campaign to:

- End discrimination
- Increase public understanding
- Treat addiction as a public health crisis.

Recovery Community

- People in recovery from alcohol and other drug addiction, their family members, friends and allies.

Paths to Recovery

There are many paths:

- On your own
- Nontraditional methods
- Support groups
- Professional treatment
- Medical interventions
- Faith
- And more.

Supporting Local Recovery Advocacy

- Increasing access to research, policy, organizing and technical support.
- 2001 Peter Hart survey of the recovery community found that half of the recovery community said that they would be likely to take part actively in a public campaign.
- Improving access to policymakers and the media.

National Survey

- Peter D. Hart Research and Robert M. Teeter's Coldwater Corporation 2004 survey:
- A majority of Americans (63%) have been affected by addiction to alcohol and other drugs.
- A majority (67%) believe that there is a stigma toward people in recovery.
- A majority (74%) says that attitudes and policies must change.

Removing Barriers to Recovery: Public Knowledge & Attitudes

Communicating to the public about recovery:

- Describing recovery
- Describing pathways
- Messengers: people in recovery, family members.

State & Federal Policies

- Employment
- Housing
- Enfranchisement/civic engagement
- Education
- Facilitating relationships among local and regional groups
- Web site www.facesandvoicesofrecovery.org

Be living proof that there are real solutions to addiction. Join us!

www.facesandvoicesofrecovery.org

**Appendix 5.3: Randy Muck: SAMHSA/CSAT Adolescent Focus
Groups Panel Presentation and Paper**

THE VOICES OF YOUTH

Substance Abuse & Mental Health Services Administration
Center for Substance Abuse Treatment
National Summit on Recovery

Youth Focus Groups, September 19–21, 2005

- 30 youth, ages 14 – 23
- 4 focus groups – approximately 1 hour each
- Chosen from CSAT adolescent treatment listserv (nominated by programs) of over 100 facilities nationwide
- One recovery home
- Selected on basis on diversity (gender, race/ethnicity, levels of care, geographic distribution)

Youth Focus Groups, September 19–21, 2005

- Early recovery – 3 months to 2 years
- All had been through more than one treatment episode, and previous mental health and behavioral health treatment were often mentioned
- Current status (treatment, continuing care, recovery home, sober high school or college dorm)
- Recovery home – sample of 10 adolescent female volunteers

Definition of Recovery

- Growing in every respect (physically, spiritually, and mentally)
- A whole lifestyle change with everything revolving around and supporting recovery
- A mental and physical healing process
- Understanding that addiction is a disease and taking appropriate measures to address this health problem

Barriers to Recovery

- Not enough coping skills gained in treatment to deal with triggers
- Inadequate education about the nature of the disease
- No access to professionals in addiction in schools where they return
- Relationships with family and community for which they are inadequately prepared
- Returning to face hardships and trauma that have not been dealt with in treatment
- Abandoned by treatment programs after program completion
- Lack of focus on trauma and sexuality
- Eating disorders/self mutilation issues which programs did not address

- Not held accountable for actions
- Self worth is not enhanced
- Staff that are poorly paid and overworked
- Staff uninterested in listening to youth
- Continuing care is optional or not offered
- No opportunity to practice skills in real life settings
- No linkages with mentors or sponsors before treatment ends.

What is Needed for Youth to Succeed

- Appropriate transitional environment
- Hope
- Positive reinforcement
- Sense of self worth
- Constructive and supportive environment
- Individualized appropriate care
- Relevant (coping) skills
- Personal accountability framed with understanding and support

Improvements Recommended

- More family involvement
- Mentors/sponsors – before leaving treatment
- Better education about the disease of addiction
- All practitioners licensed and trained
- Treatment staff that are not overworked and underpaid
- More (gradual) transition programs (e.g., sober schools, recovery homes)
- Opportunities to practice skills in the real world while living/going to school in a recovery environment

Questions to Measure Recovery for Youth

- What is recovery?
- How are you doing with your recovery today?
- List 10 internal motivations to stay clean. How have you followed up on them?
- What have you done to improve your recovery?
- What is different in your life today versus when you were using?

Listening to Youth

- Have you listened?
- How will you incorporate this information into your recovery framework?
- How will youth continue to be involved?
- What can you do in the programs and communities where you work to support the recovery of youth?

Thank you for this opportunity on behalf of all of the youth who participated.

Voices of Youth In Recovery

**Substance Abuse and Mental Health Services Administration (SAMHSA)
Center for Substance Abuse Treatment (CSAT)**

Acknowledgements

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Abt Associates Inc., led by Melanie Whitter, PFR Project Director, with support from Candy A. Magana, Peter Gaumond and Denise Young, documented the focus group discussions and authored and produced this report.

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Introduction

The Substance Abuse and Mental Health Services Administration (SAMHSA) conducted a National Summit on Recovery on September 28 and 29, 2005, to define principles and measures of recovery, as well as describe systems of care that support recovery. SAMHSA sought the perspectives of youth on these topics by holding focus groups to gather the information.

Addictions that begin during the teen years are often different than addictions that originate during adulthood. For example, addictions that are initiated during adolescence tend to progress more quickly than addictions that develop during adulthood (Clark et al, 1998). In addition, drinking patterns established during the teen years have been found to be a predictor of alcohol dependence in adulthood (Bonomo, 2004). Alcohol Health and Research World found that persons who begin drinking before the age of 15 are four times more likely to develop alcohol dependence than those who begin drinking at 21 years of age (Grant, 1998). Adolescence is a time when proper intervention can prevent the progression of drug or alcohol use. Despite these factors, the voices of youth are often not incorporated into treatment and recovery policy and systems change efforts. For these reasons, SAMHSA felt it was critical to solicit the views of adolescents to inform the National Summit on Recovery.

This report represents the voices of youth in recovery by summarizing their words and thoughts. Input was provided by 30 teens that participated in four one-hour youth focus groups, held between September 19 and September 21, 2005. The first three focus groups took place on September 19, 2005, in Oak Brook, Illinois. Participants came from locations across the United States. One of the three groups held on September 19th comprised eleven (11) males, a second consisted of nine (9) females, and the third consisted of all twenty (20) participants representing both genders. The fourth focus group, involving ten (10) adolescent female residents of a recovery home, took place in Rockford, Illinois.

The focus groups were a joint effort between the SAMHSA/CSAT Partners for Recovery initiative, which resides in the Office of Program Analysis and Coordination, and the Division of Services Improvement. The discussions provided valuable information regarding the definitions of recovery, barriers to recovery, critical factors for successful recovery, recommendations for systems improvement and measures of recovery. The results of the focus groups were presented at the National Summit on Recovery, hosted by SAMHSA/CSAT on September 29, 2005, in Washington, D.C., and will be incorporated into systems and services development activities subsequent to the Summit.

Participant Criteria and Demographics

Criteria

Adolescents were asked to participate in the focus groups based on criteria established by SAMHSA. Participation was voluntary. Participants were requested to have a minimum of three months in recovery and an ability and willingness to express their experiences and views about treatment and recovery. Participants were selected to assure a mix of gender and diversity in terms of race/ethnicity, geographic distribution and recovery experiences.

General Participant Profile

All participants described themselves as being in recovery, ranging in duration from three months to over two years. Substances of choice for the participants included: marijuana, “pills,” alcohol, methamphetamines, cocaine, ecstasy, crack and heroin.

All focus group participants had undergone more than one episode of treatment. Several individuals received mental health treatment. Participants also described their current recovery status in numerous ways. Many youth noted that they were currently involved in continuing care, recovery homes, or sober high schools or living in sober college dorms.

Geographic Distribution

Focus group participants came from a variety of areas within the United States (i.e., Alaska, California, Connecticut, Hawaii, Illinois, Michigan, Minnesota, North Carolina, New York, Ohio and Texas) and Canada.

Gender

In total, 11 males and 19 females participated in the focus groups.

Race/Ethnicity

The adolescents were diverse representing a variety of races/ethnicities (White, African American, Hispanic/Latino, Asian, biracial and Athabascan [Alaskan tribe]).

Age

Focus group participants' ages ranged from fourteen (14) to twenty-three (23) years. The majority of the participants were between sixteen (16) and eighteen (18) years of age.

Definitions of Recovery

Focus group participants were informed that the National Summit on Recovery would be convening in Washington, D.C., on September 28 and 29, 2005. A primary Summit objective would include developing agreement around definitions of treatment and recovery principles. Participants were asked to define recovery and were informed that their perspectives would be shared with Summit participants. The adolescents responded with a number of definitions, such as:

- “Recovery is growing in every respect... physically, spiritually and mentally. I have grown so much in every single way ever since I have been in recovery.”
- “Recovery, to me, is the difference between life and death. It is something that you have to want and focus on.”
- “Recovery is a choice. It is an ongoing process that is like cancer in remission. At any point in time it can turn back to the way it was before.”
- “Recovery is a whole lifestyle change. Everything has to revolve around and support staying sober. It is an intense and hard process, but, at the same time, it is the only choice.”
- “Recovery is a healing process... like having physical therapy after a car accident. A person doesn’t realize what strength they have until they work the program. It means healing mentally and physically.”
- “Recovery is learning how to live life free from the bondage of addiction.”
- “Recovery is the chance to grow into the woman that I have wanted to be. Before I was in a dead end. Now I can be happy and proud of myself.”
- “Recovery is different from being sober or abstinent. It is actively working some kind of program to maintain a state of sobriety.”
- “Recovery is not just staying off of drugs but changing your whole life...[having] new networks of people, a whole [new] environment and state of mind.”
- “Recovery is finding different coping skills and things to do.”
- “Recovery is when you actually believe in yourself. When you recover, you are staying sober for yourself and not your parents or the recovery system.”
- “Recovery is dealing with the feelings that caused you to use [in the first place]. It is learning how to deal with feelings and reactions.”
- “Recovery is understanding what the problem is. I didn’t know I had a disease. It is about addressing this disease and finding out what [you] need to do to get better.”
- “Recovery is overcoming the mindset of wanting and needing to do drugs. It is actively taking an approach to live a different life. I needed to learn how to be myself again without the drugs.”

Barriers to Recovery

The facilitators asked a variety of questions to determine what barriers may impede recovery-oriented services for adolescents:

- Now that you are in recovery, do you still hang out with the same people or have you found a new peer group?
- How does a person create a new network of friends?
- What are other means, besides new peers, that adolescents turn to during recovery?
- What was your treatment like?
- Did your treatment programs prepare you for recovery before leaving?
- What can treatment programs do to address the problem of helping adolescents feel accepted by others?
- What kinds of messages did you get regarding relapse during treatment?
- Did your treatment programs talk about sexual orientation or trauma?
- What did treatment professionals do that was the least helpful for your recovery?

The adolescents summarized barriers under the following categories:

- Lack of individualized/appropriate care during treatment;
- Lack of post-treatment follow-up;
- Lack of access to resources;
- Returning to non-supportive environments—families and schools;
- Failure to address trauma or sexual histories; and
- Maintenance of past peer networks.

Each of these categories is elaborated below and specific comments from the youth participants are provided.

Lack of Individualized/Appropriate Care During Treatment

- Recovering adolescents are frequently not treated as individuals with unique concerns and needs. Adolescents seek information on a variety of treatment options as well as an individualized approach to their care.
- “Sometimes people need more time to recover...[people] can’t just be put on a time frame.”
- Frequently, an expectation of failure is placed on individuals. Recovering adolescents are “taught what to do when they relapse rather than being instructed on how to prevent relapse.”
- Adolescents are not taught a sufficient range of coping skills to manage everyday triggers (e.g., stress, work, raising a child or boredom).
- Treatment programs do not offer adequate education on the disease of alcohol and drug addictions.

- Treatment programs do not address co-occurring eating or para-suicidal behavior, such as self-mutilation experienced in conjunction with alcohol and drug addictions.
- Treatment programs provide minimal direction to youth struggling to understand and manage their emotions.

“I needed people to show me how to deal with my emotions...all of those suppressed emotions.”

- Adolescents do not receive effective treatment for alcohol and drug problems in psychiatric wards.

“[In psych wards] I never talked about my drug dependency...[I] didn’t relate to others. I couldn’t even get my shoes. I got shots and was put into a quiet room. That was where I did not belong. Being here in the real world helped me more than anything.”

“Psych wards helped me escape out of reality. [They] just gave me a pill for depression to send me on my way.”

“[The] psych ward was my bottom... all they did was put me on meds and [have me] walk around with no shoes for eight days. I really needed to get out of my situation and be taken away to live in a facility. Everything that I had known was taken away from me.”

Lack of Post-Treatment Follow-Up

- Adolescents do not receive recovery support from their treatment agencies upon treatment completion.

“I didn’t know what to do after I graduated.”

“My first one (treatment program) just dumped me.”

Lack of Access to Resources

- Recovering adolescents will most likely not have access to a treatment professional within their school systems.

Returning to Non-supportive Environments—Families and Schools

- Unhealthy family relationships can compromise recovery. Physical and emotional abuse, family substance use and lack of communication may put an adolescent at risk for relapse.
- Unsupportive school environments create risky conditions for a recovering adolescent. After successful treatment, some adolescents struggle with not returning to old habits.

Failure to Address Trauma or Sexual Histories

- Many treatment programs do not address trauma or sexuality. The attention given to trauma usually occurs only during initial individual screenings or assessments.

Maintenance of Past Peer Networks

- Building new peer networks is one of the most difficult aspects of the recovery process. Socializing with previous peers can lead to relapse or complicate the recovery process.

“Hanging out with old friends is the hardest thing to do... it is hard to stay sober and hang out with the same people. It may be the reason that I am relapsing.”

“I can’t be around with my old friends anymore. It is important to make new friends especially when I get a craving. My old friends are struggling [with addictions] themselves.”

“I got arrested with five of my best friends and we all got into recovery together for the initial six months. The only reason that my recovery is working out for me is because I made new friends. If I started hanging out with my old friends, it would be really hard not to use... falling back into old habits would be inevitable.”

“It is hard to find sober people. I don’t feel like I am accepted by anyone... people judge.”

Critical Factors for Success

The participants were asked several questions to determine what skills, services and systems are critical factors to support adolescents’ recovery.

- How important is it to have family included in the recovery process?
- What can programs do to involve families more in an adolescent’s recovery?
- How are outpatient programs following up after people leave treatment?
- What changes need to be made within the juvenile justice system to help adolescents who are using substances?
- In your treatment programs, what have you been told about relapse?
- How did your treatment programs prepare you to deal with trauma and post-traumatic stress?
- How do you think your treatment program(s) have helped women deal with problems that are uniquely female based?
- What are treatment programs doing to help you deal with your families once you have finished the program?
- What did treatment professionals do that was the most helpful to your recovery?

Adolescents summarized critical factors for success under the following categories:

- Developing coping skills;
- Maintaining a supportive treatment environment;
- Developing accountability and self worth;
- Providing a transitional environment;
- Assuring a constructive school environment; and
- Including family in the recovery process.

These success factors are discussed below.

Developing Coping Skills

- Learning how to express emotions and deal with anger are critical coping skills for recovering adolescents.

Maintaining a Supportive Treatment Environment

- Supportive treatment environments are key to achieving and maintaining recovery.
- Building relationships of trust with mentors, sponsors and peers is very important.

“My mentor kept visiting me. She would call my mother if she hadn’t heard from me. She would come by and pick me up... she would always keep checking on me. It made me feel like I was her adopted daughter... that she had faith in me. It was key to motivating me through my sessions and even after I graduated.”
- Environments where individuals feel accepted and can share similar experiences are essential for successful recovery.

“This is not the normal teen thing to be doing... [I] feel abnormal sometimes from the normal young girl... but then [I] come home to a house full of other girls [in recovery] that are like me. They understand and support and care about me and my well-being.”

“Knowing other people are like me [is important]...I want to see people who are sober that are my age. We need to know that other people who are young are out there.”
- Patience, honesty and sincerity are characteristics that are critical for treatment staff to exhibit in a recovery environment. Recovering adolescents can determine if “a person is just coming to work for a paycheck.”

“The staff here really care about us... here the staff really love and want the best for us.”
- An atmosphere of positive reinforcement, trust and hope, supported by treatment staff, is imperative to recovery.

Developing Accountability and Self Worth

- Development of a sense of self worth is fundamental in the recovery process.
- Enforcement of rules and regulations is necessary to a successful treatment environment.
- Accountability within the treatment environment is crucial. Adolescents do not want to be “babied.”

“What helped me the most was [staff] holding me accountable. What I was living was not real.”

“We need to know that our choices not only can hurt us, but others as well.”

Providing a Transitional Environment

- Supportive transitional environments post-treatment, such as a recovery home, are important to maintaining recovery.

“Here, I get to bring what I learn into the real world. I am not confined. Here I am able to go to school, get a job and learn how to live a sober life.”
- Continuing care and recovery support programs are essential supports post-treatment. Typically, these services are provided only on an optional basis post-treatment or not offered at all.

Assuring a Constructive School Environment

- Supportive school environments are important to maintaining recovery. Counseling and weekly support group meetings located at school would assist those in recovery.

“Having options would be helpful, even if we did not attend all of the sessions.”

Including Family in the Recovery Process

- Family involvement in the recovery process can be critical. It allows for the building or rebuilding of relationships.

“My biggest problem was not having my family more involved. I wish they were more educated about what was happening to me.”

“[Family group] gave me the opportunity to communicate with my parents. I wasn’t scared of them anymore. Building trust was the biggest aspect of my recovery. My parents are a resource to me.”

“My mom was the only one who was always there [during recovery]. She never left me. My friends weren’t there [for me]. They never called. My mom was the only one who stuck around.”

Recommendations

Recovering adolescents were asked for their recommendations for improving treatment and for supporting the recovery process. They responded with the following recommendations:

- Include opportunities for more family involvement within the treatment process;
- Allow parents/guardians to connect and share their experiences with other parents/guardians who are going through the same processes with their adolescent;
- Assign mentors/sponsors to adolescents in recovery before they are discharged from treatment;
- Provide comprehensive education on the disease of addictions;
- Employ licensed and trained treatment counselors;

“They have degrees in sociology or psychology but they need [to hire] people who have taken extra classes before they come in contact with patients. They bring their experiences into treatment, but it sometimes clashes with kids, because they talk to us like we are nothing.”

- Minimize overworked and underpaid treatment staff; and
- Provide more (gradual) transitional programs.

Questions to Measure Recovery

Focus group participants were asked to provide specific measures for determining the progress of an adolescent’s recovery. Participants responded in the following manner:

- “How are you doing in your recovery today?”
- “What is recovery? If a person cannot answer that, then more work needs to be done.”

- “List ten internal motivations to stay clean. Have you followed up on them?”
- “What have you done to improve your addictions?”
- “What is different in your life today versus when you continued to use? It really is all about change.”

Conclusion

In conclusion, several major themes consistently emerged from the focus groups, when adolescents were asked their views about treatment and recovery. These important points include:

- While the definition of recovery is expansive and differs from person to person, it often includes growing in several capacities (mentally, physically and spiritually) and embracing a complete lifestyle change.
- Adolescents face a number of barriers in the recovery process:
 - Lack of individualized/appropriate care during treatment;
 - Lack of post treatment follow-up;
 - Lack of access to resources;
 - Returning to nonsupportive environments;
 - Failure to address trauma or sexual histories; and
 - Maintenance of past peer networks.
- Several critical factors are necessary for success in the recovery process:
 - Developing coping skills;
 - Maintaining a supportive treatment environment;
 - Developing accountability and self worth;
 - Providing a transitional environment;
 - Providing a constructive school environment; and
 - Including family in the recovery process.

The information gathered from the adolescent focus groups provides a valuable resource to service providers and policy makers examining adolescent services and systems of care. As stated in the introduction, the voices of youth are often not incorporated into treatment and recovery policy and systems change efforts for adolescents. However, the voices and experiences of adolescents in recovery can contribute greatly to improving the quality of current and future services. Although numerous barriers to recovery were identified, adolescents also provided great insight into factors that are critical to an individual achieving a successful recovery process and recommendations for improving treatment and supporting recovery. This report should serve as a guide for those in the substance use disorder field to develop recovery-oriented systems for adolescents. Further efforts to engage the perspectives of adolescents should be considered in system improvements.

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Appendix 5.4: William White: Comments Following Panel Discussion

William White: Comments Following Panel Discussion

William White, noted author and historian of addictions treatment, is a Senior Research Consultant at Chestnut Health Systems/Lighthouse Institute in Bloomington, Illinois. Mr. White served as panel discussant, commenting on various aspects of the panel presentations and on other themes that were emerging at the Summit. Among his observations and suggestions:

- The emerging consensus at this Summit that recovery-oriented systems of care should be person-centered is an important development. It is important, however, that the crucial family- and community-centered aspects of recovery work are not forgotten.
- The emphasis on making sure that the recovery community is authentically involved in the design and review of recovery-oriented systems of care is commendable. However, the phrase “recovery community” suggests something monolithic, while the phrase “recovery communities” more accurately reflects the great diversity—including adolescents, the elderly, people of color, varying roads to recovery—that characterizes those seeking and finding recovery, all of whom need to be at the table, stay at the table, and respect the right of others to be at the table.
- The clear indication at this Summit of a growing interest in spirituality is to be celebrated. However, references to “spiritual” should be accompanied by references to “religious” (which is not the same thing) and also to “secular”. Every time one of these constructs is mentioned, the legitimacy of all of them should be explicitly reaffirmed.
- There is a clear consensus at this Summit of the overwhelming need for prerecovery and posttreatment services, and that peer recovery support services that seek to promote recovery initiation and prevent relapse have the potential to carry a message of hope into every community so powerful that it will penetrate denial.
- There is a dialogue, now, as to where to locate peer recovery support services. Are they better housed within or as adjuncts to traditional treatment systems, or should they be located in free-standing recovery support and advocacy organizations? They need to be piloted in both settings, and subjected to evaluation.
- There is always the risk of unintended consequences. If Federal funding for peer recovery support services erodes the service ethic of recovery communities, our communities will be harmed, not helped, by this initiative. Peer recovery support services need to be designed and implemented in such a way as to honor and engage the service ethic of recovery communities, not replace it.
- A Code of Ethics for peer recovery support services, filtered through multiple communities of recovery, is a critical need. Without this, the field is vulnerable to perceived breaches of ethics, including business ethics.
- The question has been raised here as to what is the appropriate role of the Federal government in supporting the trajectory of recovery. Perhaps most important is to pioneer financing models to shift from a sole focus on acute care to sustained support for recovery. Federal leadership is desperately needed to move beyond rhetoric to develop national funding models that are tied to stage-appropriate services.

Appendix 6: Recovery Graphics

Appendix 6.1 Individual and Environmental Components of Recovery

Individual and environmental Components of Recovery

For recovery to be successful, change is required of the individual and in the environment. An interplay is necessary between the individual and environmental changes that creates hope, purpose, potential, respect, and meaning.

Individual Components of Recovery

Healing and Reconstruction

- Internal and external
- Sense of self
- Developmental growth
- Physical wellness
- Emotional wellness
- Mental wellness
- Spiritual wellness

Personhood

- Self reliance
- Self esteem
- Personal resourcefulness
- Self determination
- Self care

Environmental Components

Social relationships

- Mutual support
 - Family
 - Friends
 - Peers
 - Neighbors
 - Colleagues
- Community affiliation
- Full citizenship
- Sense of home

Meaningful activities

- Job and career
- Education
- Service and volunteer opportunities

- Leadership development
- Sports and exercise
- Hobbies

Resources

- Livable income
- Safe and decent housing
- Healthcare and social services
- Transportation
- Means of communication
- Recovery supports

Appendix 6.2 Recovery and Wellness Model

Recovery and Wellness Model

Treatment and abstinence lie at the center of this recovery and wellness model, encircled by three layers depicting areas in which change occurs during recovery: 1) life skills, 2) support systems, and 3) wellness, wholeness, balance, and culture. The components of life skills and support systems are listed below:

Life Skills

- Coping mechanisms
- Employment/treatment
- Financial stability
- Dealing with feelings

Support Systems

- 12 steps
- Living conditions
- Spirituality
- Family of choice
- Community
- Criminal justice
- Mental health
- Family

Appendix 6.3 Service System Progression Model

Service System Progression Model

Three service systems paradigms are presented in model form, each are provided showing the progression of an individual with substance use disorder through systems of care to the achievement of a healthy life in the community. The first views “effective treatment” to a healthy life in the community; the second shows the individual progressing along a circular continuum of care from detox through treatment episodes and subsequently on to healthy living in the community.

The third shows a recovery-oriented system of care in which the individual with substance use disorder is served by many systems within the community—treatment, peer support, housing, family, budgeting, social support, work or school, and faith communities. In the fourth, the recovery-oriented system of care is depicted again, along with this question: What connections are not yet in place for the person and what needs to be done to establish or cultivate them? The answers to the question can be any of the systems depicted—treatment peer support, housing, family, budgeting, social support, work or school, and faith communities.

Appendix 6.4. Building Resiliency, Wellness and Recovery—A Model for Prevention and Management of Substance Use Disorders

Building Resiliency, Wellness and Recovery—A Model for Prevention and Management of Substance Use Disorders

This model depicts the individual nested within the family and community and receiving person-centered culturally appropriate care. Four types of interventions surround the individual—prevention, intervention, treatment, and recovery supports. These are nested within risk and protective factors and recovery capital, and the outer layer of the model comprises wellness and recovery.