Recovery and Recovery-oriented Care: Foundations and future considerations

Host:

Good afternoon, and welcome to the first session of the Recovery to Practice webinar series. Today's session is titled Recovery and Recovery-oriented Care: Foundations and future considerations. My name is Pam Rainer and I'll serve as your moderator today. Laurie Curtis, the project director for Recovery to Practice will begin after I review some housekeeping tips with you. First, I would like to acknowledge our webinar participants. We have, approximately 280 people in our audience today. On behalf of the Substance Abuse and Mental Health Services Administration, we would like to welcome you all and thank you for your participation today. I would also like to thank our presenters, Laurie Curtis and Lauren Spiro, for sharing their expertise on this very important topic today. Let's review the page layout, to help you get the most out of the webinar features. If you experience technical difficulties during the webinar, please enter your question in the technical chat box on the screen and the coordinator will respond to you directly. You can also download a PDF version of today's presentation. And, a certificate of attendance from the downloads materials box, below. Webinar is broadcast via your computer, to make sure your speakers are unmuted and you adjust your volume as needed. Have also posted webinar a valuation link, which will appear in the box below. Both at the beginning and at the end and we hope at the end of the presentation, you will take a moment to complete that a valuation. You may also enter a question in the Q&A chat box at any time throughout the presentation. The presenters will respond to as many questions as possible at the end of the presentation. You can post your questions at any point they arise for you. Now, I'm going to turn the microphone over to Laurie Curtis and she is our project director and will provide background information on SAMHSA's Recovery to Practice and she will introduce our speaker, Lauren Spiro. Laurie, go ahead.

Laurie Curtis:

Thank you. Welcome, everyone. We are delighted you are able to take time with us and join us for this webinar. Our topic today is on Recovery foundations. A colleague and advocate for recovery-oriented approaches and Behavioral Health, and a very smart person, described "recovery" as one of the most powerful words in our behavioral health lexicon. It creates real lives, promotes hope and can open doors to enlighten and have dramatic care reforms. The promise and actuality of recovery has transformed the mental health and substance use landscape in ways almost unimaginable a decade ago. People with experience and peers have fostered this mission and SAMHSA has made this vision an everyday reality for many.

Historically, people with serious mental illnesses and substance use conditions were widely assumed by community members, by professionals and even by ourselves, to be in a permanent state of chronic illness, a state

of defeat. These concepts have persisted very broadly, even into our recent times, despite evidence to the contrary.

Recovery is not a journey alone. Other people, peers, family members, friends and practitioners, are fellow travelers on the person's road to recovery. A practitioner who understands trauma can play a key role. So can the community that reaches out to be inclusive and offer support.

The efforts of the Substance Abuse and Mental Health Services Administration, also known as SAMHSA, have helped clarify the characteristics and meaning of recovery in everyday life, as well as its fundamental importance to everyone with a mental health or substance use condition.

SAMHSA's definition of recovery focuses on four major dimensions that support a life and recovery. These are health -- overcoming or managing diseases. They include home, having a stable place and safe place to live. Purpose -- meaningful activities and things to do that make meaning in one's life, such as a job were volunteering or taking care of the family, creative resources. Community – our relationships and social networks that provide support, and friendship, love and hope.

In 2011, SAMHSA released a new working definition of recovery and a set of guiding principles. The revised working definition and principles incorporate aspects that were missing from the first set of SAMHSA dimensions of recovery. These underscore that an individual may be in recovery from a mental health disorder or substance use disorder, or both.

The four major dimensions, home, health, purpose, and community and these 10 components and Behavioral Health, form a strong structure and foundation for developing recovery-oriented the lives and building systems.

To help the field incorporate these principles, and to help the behavioral health workforce bridge from where we have been over the years, to where we are going, SAMHSA initiated the Recovery to Practice initiative. Recovery to Practice, also known as RTP, is a workforce development initiative that focuses on integrating recovery into behavioral health care or multiple disciplines and service settings.

The initial phase of Recovery to Practice initiative was launched in 2011 and focused on working with six professional disciplines to create discipline-based curricula that promoted the uptake of recovery principles and practices. Each of these disciplines had the latitude to to use the language and framework that made the most sense for them and for their membership. Each discipline developed the ways to integrate the curricula into their disciplines' professional development activities, including academic preparation, residency, education, continuing education events, certificate programs, certificate certification procedures.

These are the six disciplines that developed the initial Recovery to Practice curricula. The American Psychiatric Association, with the

American Association of Community Psychiatrists. NAADAC, The Association for Addiction Professionals, the Council on Social Work Education, the International Association of Peer Specialists, the American Psychological Association and the American Psychiatric Nurses Association.

To a large degree, the curricula are in the public domain and each association has a webpage dedicated to Recovery to Practice. Google "RTP" and the association name and it will help you get there. You can find information about each of these curricula on those websites.

This webinar is the first in the series that draws from these discipline-based curricula to make that information available across disciplines and to others who may not be members of these particular professional groups. During this webinar series, we will highlight some of the core messages that link these curricula and run through them to underpin all recovery-oriented practices.

Some of these messages focus on the fact that people with behavioral health conditions have been, and many still are, subject to prejudice and discrimination. Yet, we also have fundamental human right, and restoring them is necessary to live meaningful lives in our community of choice.

With this history of discrimination, has come a high degree of pessimism: "people with serious mental illness simply do not get better and often require lifelong care". We know that this is not true.

One of the things that communicates discrimination and pessimism is language. Language is a powerful, powerful tool and communicates our assumptions and expectations on many levels. Person first language is an important step in restoring persons and individuals.

In the recent decade or so, we've begun to invite people with lived experience to the table in policy, research, and as service providers. Yes, as colleagues. The field is beginning to understand that we have valuable insight into what works, and does not work, and why.

We know that with person goes self-determination and choice. They are central to the life of each one of us, including those living in recovery. While the system of care includes access to treatment, recovery support, and for medication as recovery support, too often, they have been insular, forming small worlds and structures from the broader community.

We know recovery lives in the broader social context and that being part of an accepting community and feeling part of this important thing is important for many of us. Few of us recover in isolation from others. Yet, there can be no one-size-fits-all for recovery. For each of us, recovery is culturally based and influenced and that is part of our richness.

Finally, new approaches need new ways to think about outcomes. What does recovery look like? How can something so individual be measured and evaluated and be assessed?

These are some of the themes coming through the curricula from the first set of Recovery to Practice. The second phase of Recovery to Practice, we are moving a little bit away from some of the discipline specific curricula and are looking more broadly to multidisciplinary and integrated services and settings. In this phase we are positioned to support wide dissemination and uptake of the recovery-oriented practices and principles among professional organizations, agencies, training institutions and other stakeholder groups. We continue with the overarching goal of improving competence and skill in the behavioral health workforce to transform the general concepts of recovery into concrete in everyday practices.

One way we are doing this, is through this webinar series, which is presenting foundational information derived from the discipline-based curricula and making it available to wider audiences. Each of these webinars will be recorded and archived for future reference and use in training or other professional development activities we will continue with these webinars next year.

A second webinar series is in development, as we speak and focuses on decision support for clinicians and physicians. We expect to make those webinars available soon. Another thing we've been doing, is developing new resources for Recovery to Practice.

Right now, in the pipeline, are two resource manuals. One is on multidisciplinary practice applications and inter-professional collaboration, and one focusing on peer specialists, working with people who experience homelessness. Each of these manuals will be followed by an interactive learning module, which we had also will develop in the upcoming years.

We are also continuing the rich Recovery to Practice tradition of excellent newsletters to the field. Issued quarterly, the Recovery to Practice newsletter focuses on timely issues, current thought leaders provide tips and resources and events of potential interest. If you are not now receiving the Recovery to Practice newsletter, please take a moment to sign up at RTP@AHPNET.com.

All right. With that, I'd like to introduce our speaker for today, Lauren Spiro. Lauren's vision of social justice and mental health liberation fueled her work. She is focused on developing our capacity for feeling deeply connected with each other and appreciating the vast creative intelligence of the human mind. Building pathways so everyone may come home, inspiring compassionate action, and spreading innovative collaboration, healing and community development. She is a visionary thinker, educator, artist and consultant dedicated to embodying inner peace and global peace. She has been featured on international media, consults with numerous Federal and state and local projects and cofounded Emotional CPR, and two nonprofit mental health corporations, serving until recently as the director of the National Coalition for Mental Health Recovery. She is a blogger and author of a recently published memoir, *Living for Two: A Daughter's Journey from Grief And Madness To Forgiveness and Peace.* She is a survivor of chronic schizophrenia

diagnosis and has an MA in clinical and community psychology. With that, I will turn it over to you. Thank you.

Lauren Spiro:

Thank you so much. I'm delighted to cope present with you today. I would like to start with a brief overview of some of the milestones in the recovery movement. We can go to the next slide.
I want to share about the 1950s, we have development of Alcoholics Anonymous and the first addiction self-help group in the movement. The 1960s we have the civil rights movement followed by the women's liberation movement. It brought in an era of increased awareness of human rights and justice and civil rights violations. The conditions endured by mental patients. In the 1970s, ex-patients began to form support groups, self-help groups. Skip to 1985 where we have the first SAMHSA-funded Alternative Conference. In 2001 Faces and Voices of Recovery was formed, and the National Coalition Mental Health Recovery formed in 2006. In 2009 we have the SAMHSA Recovery to Practice initiative which I have been on from the start, I'm happy to say. In 2010, we have SAMHSA's integrated components of recovery, which Laurie went over, but I will go in more detail.

In this slide, it focuses on some examples of where recovery has been supported by legislation. In 1980, we have CRIPA -- the Civil Rights of Institutionalized Persons Act that helped protect and enforce the rights of people in institutions. In 1990, we have the ADA, Americans with Disabilities Act which allowed more access to people with disabilities. In 1999, we have the Surgeon General's report, which was optimistic about recovery and rehabilitation. If we could go back one slide, we are on how recovery supported by legislation. In 2003, it was exciting to have the New Freedom Commission Report come out that said recovery is possible for everyone.

Then, in 2010, of course, very exciting Affordable Care Act which took decades of education and advocacy to the path of Congress making healthcare, making mental health care and addiction care on par or equal to healthcare. The ACA for mental health and addiction, it brought mental health and addictions care too many millions of people.

Before I start talking about some of the current behavioral health initiatives that are working, I would like to appreciate a larger context of some of the challenges and opportunities we face going forward. I'm going to share only three brief points of data on what is not working.

Point 1: Is a 2006 study said that adults receiving behavioral health treatment in the public sector die decades prematurely due to preventable conditions. Cardiovascular disease is associated with some of the largest numbers of deaths. Some of the other reasons for premature death are poverty and homelessness, unemployment, side effects of psychotropic medications, social isolation, trauma and discrimination.

Point 2: In 1955, began a psychopharmacological revolution. The disability rate leads to mental illness as measured by adults under

government care, and has risen from one in every 468 Americans in 1955 to one in 76 in 2011.

Point 3: A study conducted by the National Institute of mental health, on the long-term use of medication for children diagnosed with ADHD, found at the end of the third year, that medication – and I quote, "was a significant marker not of beneficial outcome, but of deterioration". Next slide, please.

Now, we are going to review some of the evidence of recovery-oriented factors. SAMHSA has been working for many years to further understand and use recovery-oriented services. One aspect of this work is to identify evidence-based practices that promote and support people in recovery from behavioral health conditions.

An important practice provides people with support they need to live in decent, affordable housing, and help people achieve basic dimensions of recovery, which is having a home – a stable and safe place to go. SAMHSA has information on affordable housing and other recovery-oriented practices that I will go over, available as a free download from the SAMHSA Store.

Next, another example of a service approach that helps people in recovery with employment. There are a number of different approaches to employment. The basic premise is helping people participate in the competitive labor market, helping them find meaningful jobs, access to ongoing support from a team of specialists.

For education, another example is focusing on helping people move toward their education goals. This may help people move out of poverty and contribute significantly to recovery and integration. It helps people find and embrace the purpose with relationship and expand the goal to have greater access to resources and community integration.

Next, peer run services are often stand-alone agencies or programs owned and operated by people in recovery. And, it may include programs, outreach and support, and there are examples of peer run support employment and education, among many others. Of note, a growing number of peer run services, which I find very exciting, offer short-term diversion settings that support individuals experiencing -- or at risk of -- experiencing an emotional crisis, using a peer run system. Peers provide significant cost savings and they can offer improved outcomes -- including, but not limited to people feeling more socially connected, increased trust and social inclusion, as well as reducing experience of trauma and use of inpatient and emergency services are reduced.

One program I want to mention specifically, is an interesting partnership between providers and peers and it is publicly funded. It is in Santa Cruz, California. In a two-year study, they found that people using peer respite were 70% less likely to use inpatient or emergency services compared to a control group that did not use respite. The control group has similar characteristics to the group that used peer respite, such as similar diagnoses, service history, demographics, etc. I want to make it really clear that after a stay in a peer run respite, people were 70%

less likely to need inpatient or emergency services. That is a big number.

Next slide, peer support is an approach that overarches all these goals. Whether they are peer-run or conventionally-run, peer support / mutual support is rooted in the premise that people who share similar experiences, such as mental health or addiction conditions have unique insights and abilities to support and engage and provide hope and empathy and validation and information that contributes.
Research shows that peer support services promote empowerment, self-esteem, self-management, engagement and social inclusion. Truly, a social network of received services. Review of meta-analysis, research findings identifying values that peer providers offer and benefits to peer support, including but not limited to -- and I'm quoting from research, “reduced use of hospital days, ability of psychiatric systems, criminal substance involvement, increased self-esteem, self-efficacy, empowerment”.

And here are other ones. In 2007, the Center for Medicaid and Medicare services (CMS)defined reimbursable peer support services as “evidence-based mental health models of care” and also, requires that new health-home applications include peer support services. Making big changes and inroads!

In 2008, the Veterans Administration released a handbook on Uniform Mental Health Services in VA medical centers that states all veterans with at risk medical illnesses must have access to peer support. As of 2013, they had hired 815 specials who are working at every VA medical center throughout the country. The largest use of peer services in the United States, is the VA.

Next slide, Western Lapland in Finland has the best outcome in the Western world for first-break psychosis. They have five years of outcome data that show 80% of people after experiencing first break were either working or are in an education program at school. Why is this? The psychiatric community in Western Lapland is as minimal compared to the US. In Lapland, 33% of the folks that come into service with a first break psychotic episode have been exposed to antipsychotics. And only 20% of them are regularly maintaining on the drugs.

So, they understand mental health problems through communication. They use a social networking with a person-directed approach to understand communication and deal with and resolve emotional crises. They put the person first -- the person in emotional distress is determining the actions that will be taken, where they should be, and who should be at the meeting. Really, all aspects of care. They primarily are interested in what the person in distress wants and needs. They work around that person's framework, their desires, goals, interests.

These results are the reverse of what we see in the United States. The US, as I mentioned, has a large number of people in facilities and very small percentage Indiscernible-low volume].

Next, in many respects, people in recovery have been leading the way in other countries and the field is learning from their leadership, innovation, their organizations, their demonstrations that recovery-oriented practices work. But there's more to be hopeful about. Practices are emerging that can have profound effect on treatment. They are not, necessarily service models per se, but approaches that help embed recovery principles into multiple service settings.

One of these approaches is shared decision making – a process that changes conversations between individuals and service providers. It is built on the assumption that individuals and service providers are experts in their own right. Shared decision making helps people come to dialogue and make effective treatment and service decisions. Effective services must fit the needs of the person, as well as their preferences and values.

Many of us think we already do shared decision making, been there, done that. But we are finding that when people begin to use the tools that are emerging in behavioral health, most of us fall short of shared decision making. Some of the tools come from SAMHSA and others from other Federal agencies such as Agency for Healthcare Quality and Research (AHRQ), institutions such as the MAYO Clinic, and innovators such as Patricia Deegan and her CommonGround program.

Next, another hopeful aspect in our field is the current movement toward whole health approaches with the premise that the mind and body are intricately connected. There are many resources emerging in this area. This slide, for example, points to the Service Center for Integrated Health Solutions, that you may want to check out.

Next, a final example of hopeful directions is self-directed care(SDC), which is a relatively new and promising model that has not yet been established as evidenced-based practice. SDC is a fiscal approach; it gives people purchasing power. We all want that, right? The power to determine and purchase their own services and support. It’s a model of health care financing, in which the individual has the power of resources and authority to choose services they determine will support their journey. These approaches have been piloted by the Robert Wood's Johnson Foundation, the “Cash and Counseling” Program from the Center for Mental Health Services. It has been piloted in a number of states including Oregon, Maryland, Pennsylvania, Texas and elsewhere. Laurie, did you want to add anything, at this point?

Laurie? Maybe not. Laurie can jump in if she wants to.

Laurie:

I was on mute, I'm sorry. I just want to add that SAMHSA funded the Pennsylvania Office Of Mental Health And Substance Abuse Services CHIPP program (which stands for Community/Hospital Integrated Projects Program), that uses some self-directed care approaches to successfully help people move out of institutional and hospital-based settings. Folks can get more information on this program through a recent publication that came out from the Mental Health Association of Southeastern

Pennsylvania. You can see the link for that in the "participant evaluation and publications" pod to the lower right on your screens. Want to make sure that we did a shout out, Lauren. Thank you so much.

Lauren:

The next slide, I want to make sure we insert this. This is a quote. It comes from Marvin Southard, Director of the Los Angeles Department of Mental Health. He used this quote on one of the RTP CSWE webinars that we did. The quote is, "When we put the client voice at the center of our decision-making, we find out that we make decisions that make a better system and make recovery a possibility for greater numbers of human beings". Love that.

The next slide, next several slides, are a review of SAMHSA's Guiding Principles of Recovery. Keep in mind, that we want to make sure we have time to hear from you all.

This first one is really nice, I think, for all of us. Expect the unexpected. Recovery, like life, is individual and nonlinear. Thank you, SAMHSA. Each of us has a big invitation to follow and deeply integrate these components of recovery into every aspect of our services program and organization.

Next, is hope. An essential factor in the recovery process is certainly hope.

Also, the presence and involvement of people who believe in persons to recover. People support and encouragement and provide information and resources during change. I'm going to move ahead and look at this. I like this slide and I will say what is on that piece of paper:"Each of us has the power to choose, the power to change".

Next, recovery occurs in many pathways. Human beings, as we all know, are unique. We have to think through strengths and resources, and experiences are individual pathways to recovering and our pathways may include peers, professionals, use or non-use of psychopharmacologicals. Supports and families, faith-based or spiritual communities and other services as appropriate. Recovery, I have found, is a winding path with twists and turns, highs and lows. It has continual growth and leads to health, whatever that may look like for this individual. A supportive environment is particularly important for vulnerable children who may not have the legal protections needed to set their optimal course. They need to be mindful about protecting the dignity and rights of our children.

Next, is the slide that recovery is individual and person-driven. Individuals defined their own goals and define their unique path toward those goals. We will move on.

Individuals have responsibility for our own self-care. That should be supported. Families and significant others have responsibilities to support their loved ones; communities have responsibility to provide opportunities and resources to address determination and foster social inclusion in recovery. It also has social responsibility and should have

the ability to join with peers to speak collectively about their needs, once and aspirations.

Next, recovery, like life, is full of risk and encompasses mind, body and spirit. Practices, housing and employment and education, clinical and nonclinical services. Physical health, alternative services. Creativity, social networks, transportation. Integrated and an array of services available should be accessible. Culturally responsive integrated and coordinated. Okay.

Next, recovery does not happen in a vacuum. Recovery happens in context. It is supported through relationships and social networks. It is critically important that people believe in a person's ability to recover. With a full life. Anyone can be part of a vital support network. People may be unaware that they are part of someone's network. Support may come from a clerk in a shop, a thoughtful neighbor, a coworker. Good people may not realize the positive impact that they have on others. Relationships -- people take risks. Engage and caretakers, the list is long -- it is individualized, as we've been talking about. Taking risks to tie different roles these two were -- leads to a greater sense of longing, social inclusion.

Next, peers encourage and engage other peers and provide each other with a vital sense of belonging. A valued role and community. As a peer, we can truly say I understand. I've been there. We provide a beacon of hope to those who have trouble seeing the light at the far end of the tunnel. Think about the role of peer support and the role for allies of children and youth. How do we show that we believe in their innate wisdom and unique needs and abilities?

Next, the experience of trauma, such as physical or sexual abuse, and that is often a precursor to developing the position. It's really essential.

Next, and I am watching the clock -- recovery is culturally based. Culture and cultural background involve representation of values, traditions. They are key in determining a person's unique path to recovery. Services need to be culturally grounded in the community.

Next, the Council for social work education, CSWE, they will address this culture when we have another the webinar. Integrating the six discipline’s curricula, the RTP project is itself an integration of cultures . If we look on a deeper level, each one of us is invited within the realm of our responsibility to be mindful about cultural humility. Let's think about what that means. How we might integrate it. All of these ideas are in the CSWE curricula: the ability to engage for oneself; ownership of our biases, our judgments and stereotypes; being aware that we have the willingness to see the world from a different perspective; the ability to walk in someone else's shoes. One of the most important things, is using curious inquiry and respect, to differing perspectives, ideas, feelings, and actions, with an open mind and open heart.

Let's see, the Council on social work education (it is one of the original RTP disciplines) not only developed curricula, but also been

taking a close look at their structures and standards that guide social work throughout the United States. They developed set of practices and mental health recovery which integrate recovery principles throughout the 10 Educational Policy and Accreditation Standards that describe what is required of social work professionals. Here are some examples and you can click the link and get more information, if you like.

Next slide, start where you are. Really, each of us can always do our best. We start where we are and do what we can. It is on our watch, however, to co-create services that exemplify inclusion, human dignity and mutual respect, self-determination and coordinate and work collaboratively, not only across disciplines, but embodied into the broader community.

The standards we set and the policies and practices we adhere to that help people recovery and have a full life are the same ways of being that build strong, healthy communities. Listening to each other, and using our hearts and minds to see new possibilities and then create the pathways to an integrated system. Our culture of respect affects everyone. Our reach impacts all sectors of society from law enforcement and criminal justice to youth and aging services to schools, and public service systems. Our work is to create a culture that nurtures and respects everyone. It is not us verses them. It is 'us', becoming 'we'.

Change starts with each one of us. We are excited about RTP as we get into the details, not involved with how we actually do the work with integrating, but into practice. RTC -- IDP is an invitation to listen to each other with our hearts and mind and see possibilities and create pathways for systems. Demonstrating to be hopeful and grounded in our values. I have been talking too much. I am going to turn it over to you, Laurie.

Laurie

Okay. Thank you, Lauren. Thank you for that wonderful presentation. You covered a great deal of ground in not an awful lot of time, good job. What we would like to do, at this point, is to open it up for questions and answers. We had planned to put in an interactive exercise, but we see that we've been getting some questions from the audience and we think our time is better spent by addressing some of those. Pam, I think you are tracking some of those questions. Would you help us and raise those so that Lauren and I might respond to them?

Host/Pam:

I would be happy to. They're coming in different categories, so I will try to put them together and see if we can group them and save time. There's a lot of questions about the curricula that was developed, how the specific groups were selected and to what extent the disciplines are using the curricula. That encompasses a couple of questions.

Laurie:

It does. There's a couple of ways to approach that. The disciplines were selected in combination with the organization that first was managing

Recovery to Practice, the disciplines themselves, and SAMHSA. There was kind of a coordinated effort to identify some of the disciplines that have the largest membership, the largest reach, and some of the deepest impact on the field. Of course, they are not the only organizations involved in recovery-oriented practices or behavioral health practices across the United States and that is one of the things we are trying to pick up a little bit more through Recovery to Practice two – or the second phase of the project –sread the impact and accessibility a little bit farther. We no longer have the funding opportunities that were available in the initial Recovery to Practice to do field-based product development. But, they're moving forward with trying to encourage use and uptake and adaptation with existing materials, the awareness that they are out there.

I forgot the second part of your question.

Host:

I think you answered it. How are different disciplines using the curricula?

Laurie:

Let me answer that. The different disciplines use the curricula and very discipline-specific ways. Some are integrating the materials into new professional training such as an academic and college settings. Some of them begin to look at ways to integrate the material into a new recovery certificate -- kind of a competency or a specialized knowledge area. Others use it for professional development kinds of activities. There is a wide range for how the different disciplines are rolling it out.

Host:

Okay. Thank you. We are getting a lot of questions, relevant to peer support specialists, and I am going to grab a couple that have our broader application and we will get through as many as we can. This is from Scott and he asks, "What is the most successful phase of incorporating peers afford in two reimbursed services -- peer support so others can use that as a role model -- role model use?"

Lauren:

If you could speak louder, it would be helpful. Many states are using peer specialists as Medicaid reimbursable services in a variety of roles. Very unique to the states.

Host:

Okay. Is there an overall resource that you could point to that someone could do research on that area?

Laurie:

Terms of specific funding, Pam?

Host:
I think the application, the use of peer support within a state, is there any kind of website that people can go to or something they could look to, to find role models?

Laurie:
I think there are a lot of role models out there. The idea of clicking on the state to see what happens for recovery, or for peer-based services, to my knowledge, it doesn't exist. It is a wonderful idea, but I am not particularly aware of a resource like that. Are you, Lauren?

Lauren:
I am really not. My best stab or guess at this point, you might want to Google the "Pillars of Peer Support". There has been great work in Georgia at the Carter Center. Discussing this. I don't know if iNAPS has new data, certainly peer support, there are some reports.
Laurie:
Another resource in that domain would be to take a look at the BRSS TACS website, another SAMHSA project called "Bringing Recovery Support to Scale, Technical Assistance Center Strategy", which is a mouthful and why it is called BRSS TACS acronym! If you Google BRSS TACS, they have a number of strong and useful resources on peer support worth checking out.

Lauren:
That reminds me, BRSS TACS is SAMHSA funded. The other resource is the SAMHSA website. I believe the BRSS TACS website is found through the SAMHSA website.

Pam/Host:
I'm sorry. Thank you to several participants, they are riding in a lot of resources -- writing in a lot of resources. Mental health America, INAPS, Georgia Peer Support and Wellness Center. Thank you for putting those in there. Okay. Let's go for another one. This is from George, who says he comes from a substance abuse background and that AA and other 12 step groups spearheaded self-care in addiction communities. And, the recovery movement seems to try to accomplish the same thing from the opposite direction, kind of top-down as opposed to bottom up and asks, do you agree or not, and how do these approaches compare? Could the mental health community benefit from more of a 12-step type of involvement? Or, movement, excuse me.

Lauren:
Thank you for that question. Who know that recovery is individual. Very individualized. Mental health recovery movement, and I know more about the mental health than the addiction recovery side of it. I would say it is top-down, but it is very, very bottom-up. Most of the innovation and mental health recovery has been created by peers. The ideas have come from peers. We have Faces and Voices of Recovery – a national addiction peer run organization, and the mental health -- the National Coalition for Mental Health Recovery is the national peer run mental health

coalition. There are some bridges between them. We've had a number of dialogues, bringing in national leaders to discuss the differences and similarities. Those have all been SAMHSA-funded efforts. I hope that answers your questions.

Laurie:

Let me add just a little bit. The issue, as you are saying, is not either or. Many people benefit from 12-step programs. There are 12-step programs in the mental health arena, as well as substance abuse. Over the years, the development of recovery from an addictions or substance abuse perspective and the development of recovery principles and ideas from a mental health perspective, have functioned in parallel tracks. It has been in the last decade or so, that these tracks have begun to cross fertilize very richly and I think Lauren was referencing that in her early remarks. Mental health has learned a great deal from addictions recovery and addictions learns from mental health recovery. I think we are beginning to see a blending, or not so much a blending, but intertwining as each edition is valued by the respective people who cherish them. They are becoming something that we begin to learn from each other. SAMHSA has recognized that with the new principles of working definitions of recovery, which does try to integrate some perspective from both worldviews. The reality is, and I can't speak to this personally, many individuals are in recovery from mental health issues and substance abuse issues. When the service field is bifurcated, or divided, you feel you have to choose a camp, choose a side and that doesn't help our process of recovery. It is a matter of finding what works for each of us. And, drawing from the traditions that feel right and help us move forward in our lives because that is what it is about.

Lauren:

Absolutely. The movement has a lot more similarities than differences. We have been meeting on a state and national level to look at the similarities and it boils down to, I think, that if I could speak for both camps, the addiction camp and the mental health camp, we are pleased with the components of recovery that SAMHSA has developed. We were intricately involved in the development of those components. Certainly, human rights, self-determination, some of the components we have been talking about, they are core, guiding principles that are integrating as addiction and mental health and physical health become more integrated and coordinated with care. There are some differences in the philosophies, but similarities in approaches.

Host:

Okay. Thank you. I think you both brought a lot of clarity to a very important question. I know that one comes up freak when the. We are down to about 2.5 minutes. Let's see if we can get a last, quick one in. There was a reference early, to people receiving peer support services as needing to be on Medicaid. Ronald asked why it is that a person always has to be receiving Medicaid to be eligible for peer support services?

Lauren:

That is determined on the state level. The culture is moving in that direction of getting peer support to be Medicaid funded. So it is atleast funded.

Laurie:

The basic answer to that question, they don't need to be on Medicaid to get peer support services. Peer support happens between two people and it doesn't cost anything. There is a lot of peer run organizations and centers and 12-step programs, a lot of places for peer support. The VA is now offering peer support and none of these are Medicaid dependent. What is exciting about Medicaid, is that it has become a vehicle for funding some of these programs and services that heretofore have not had any funding. They are becoming recognized, established, acknowledged for being valuable. And, funded because they make significant contributions to the field.

Lauren:

You know, there is a healthy tension between some of the programs at making that choice. Do we want to be Medicaid funded? You know, adhere to all the requirements therein? To be Medicaid reimbursable, or not. Because funding is needed, and many states are moving in this direction.

Host:

Thank you. I think we can fit one more quick one in. Someone was asking a language relevant question. Under the guise of, is it stigma to use the word "survivor of"? The question is, under Recovery to Practice, is that a term typically use?

Laurie:

No. It is not a term we are using on a regular basis. I saw that question earlier. I said, I don't remember using that term. Talk about people with lived experience, and individuals. There is a lot of language that individuals may use because it reflects what is important to them and how they view their experience. It could be a consumer, and ex-patient, a survivor. As we move forward, we acknowledge those terms, but they are not terms we are promulgating or using as part of the Recovery to Practice.

Pam:

Okay. Thank you very much. That brings us to 4:00 and we really value everyone's time, so we will bring this to a close. On behalf of SAMHSA, I would like to thank our participants for taking time out of your date to attend today's webinar. I think, at one point, we had close to or over 300 participants. We know that you have demanding jobs and we really appreciate your interest in learning about recovery and recovery practices. Special thanks to our speakers, Laurie Curtis and Lauren Spiro. You bring great wisdom and expertise on this topic and we really appreciate your time and we would like to ask everyone, again, please take a moment to complete the evaluation. We value your input and we find

it helpful in developing future webinars. Also, the date and times of upcoming events can be found in the bottom right-hand side of your screen and will also be e-mailed as reminders, that you will receive from us. As you know, once you registered, you registered for the whole series. We understand that you will attend as many as you can. We are not able to offer CEU for this webinar series. However, you can click on the link and download a copy of the certificate of completion. That is under the download materials box and with that, thank you very much. This concludes our call for today. We hope you have a great afternoon. At this point, all participants may disconnect.

Event Concluded]