Building Bridges

People in Recovery from Addictions and Mental Health Problems

In Dialogue

Substance Abuse and Mental Health Services Administration

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# Contents

**Introduction and Background** ............................................................................. 1

**Overview** .............................................................................................................. 4
Meeting Participants and Process ............................................................................. 5
Dialogue Meeting Objectives ................................................................................... 5
The History of the Peer Recovery Movement ......................................................... 6

**Dialogue Themes and Findings** ......................................................................... 9
Common Experiences and Themes ......................................................................... 9
Co-Occurring Mental Health Problems and Addictions ......................................... 9
Early Use of Substances .......................................................................................... 10
Centrality of Trauma in Addictions and Mental Health Problems ......................... 11
Role and Significance of Culture ........................................................................... 12
Many Pathways to Recovery .................................................................................... 14
Social Support and Peer Support .......................................................................... 16
Discordances and Hard Questions ......................................................................... 17
Language and Terminology ..................................................................................... 17
Concept of Abstinence ............................................................................................. 19
Use and Meaning of Medications in Recovery: .................................................... 19
Concept of Coercion ................................................................................................. 20

**Dialogue Outcomes and Recommendations** ..................................................... 22
Recovery Definition .................................................................................................. 22
Guiding Principles of Recovery ............................................................................. 23
Recommendations for Advancing the Concept of Recovery and the
Integration of Mental Health and Addiction Recovery Services .......................... 26
General Suggestions ................................................................................................. 26
Specific Recommendations ........................................................................................ 27
Conceptualization, Organization, and Financing of Integrated Recovery
Services ..................................................................................................................... 27
Workforce Development .......................................................................................... 28
Peer/Consumer Recovery Support Services ........................................................... 28
Recovery Research ................................................................................................... 29
Recovery Materials ................................................................................................... 29
Promoting Partnerships that Support Recovery.................................30
Cultural Issues..................................................................................30

Summary and Conclusion.................................................................31

References..........................................................................................32

Dialogue Participants.........................................................................33
Introduction and Background

Since 1997, the Substance Abuse and Mental Health Services Administration (SAMHSA) has sponsored a series of participatory dialogues that offer mental health consumers and representatives from other groups an opportunity to enhance communication and build partnerships to improve behavioral health services and promote recovery. These meetings have led to concrete outcomes, including advances in networking, training and technical assistance, and valuable recommendations for SAMHSA and the field.

In 2004, SAMHSA’s Center for Mental Health Services (CMHS) convened over 110 experts, including mental health consumers, family members, providers, advocates, researchers, academicians, managed care representatives, accreditation organization representatives, State and local public official, and others, to develop the National Consensus Statement on Mental Health Recovery. At this landmark meeting, constituents from the mental health field developed a definition and 10 fundamental components of mental health recovery.

In 2005, SAMHSA’s Center for Substance Abuse Treatment (CSAT) held the CSAT National Summit on Recovery. At the CSAT Summit, 125 participants, including people in recovery from addictions, family members, providers, advocates, researchers, State and local public officials, and other stakeholders, developed 12 guiding principles of recovery and 15 elements of recovery-oriented systems of care. In addition, following the meeting, the Summit Planning Committee used participant input to develop a working definition of recovery.

In the years following these SAMHSA Summits, many gains have been made in integrating recovery principles into supports and services available to those in recovery from mental health and substance use problems. However, even though mental and substance use disorders often co-occur in the same individual, mental health and addictions treatment and recovery services often continue to be organized, delivered, and financed primarily in “silos” that do not correspond with the realities of people’s lives.
In 2010, SAMHSA launched eight Strategic Initiatives to provide direction to the Agency’s efforts by focusing resources on areas of urgency and opportunity. One of SAMHSA’s Strategic Initiatives, Recovery Support, has as its purpose “to partner with people in recovery from mental and substance use disorders and family members to guide the behavioral health system and promote individual-, program-, and system-level approaches that foster health and resilience; increase permanent housing, employment, education, and other necessary supports; and reduce discriminatory barriers” (SAMHSA, 2011, p. 49).

As part of its strategic efforts, SAMHSA has instituted a renewed emphasis on integrating services across mental health and addictions, as well as launching new efforts to integrate mental health and substance use treatment and recovery services with primary health care. The aim is to promote more efficient systems of care and networks of support that meet the holistic needs of individuals and families. SAMHSA is attempting to move the mental health and substance use disorders recovery fields beyond the limitations of offering services organized and delivered by service category, professional discipline, or other exigent arrangement.

Although there is general agreement that providing integrated, holistic care is important and needed, until recently, little ground has been gained in advancing a common framework to guide the integration of services across mental health and substance use disorders. With its inherent focus on strengths, personhood, optimism, healing, wellness, and community, recovery appears to offer promise as an organizing construct to bridge the divide between addictions and mental health.

At the same time that SAMHSA has been emphasizing the integration of mental health and addiction-related services, health reform has begun to precipitate fundamental changes in the way those and other services will be organized, delivered, and financed. With its focus on wellness, health reform can provide an unprecedented opportunity to highlight innovative practices and systems change efforts that promote recovery.
To keep pace with these important trends, SAMHSA convened the August 2010 meeting, *Building Bridges: People in Recovery from Addictions and Mental Health Problems in Dialogue*. The purpose of the meeting was to provide a forum for those with lived experience to consider a unified definition of recovery that would capture the essential experiences of individuals recovering from addictions and/or mental health problems and to articulate a set of principles to guide the design of integrated and holistic recovery support services. This publication describes the process and outcomes of this dialogue between people in recovery from addictions and mental health problems.

Following the August 2010 meeting reported here, SAMHSA engaged in a year-long process of continued dialogue with stakeholders in the behavioral health field to elicit comments and suggestions on the draft definition and principles developed during the *Building Bridges: People in Recovery from Addictions and Mental Health Problems in Dialogue* meeting. In addition to presentations and discussions at numerous stakeholder meetings, SAMHSA invited public comment via two Feedback Forums on the SAMHSA website between August 12 and August 26, 2011. Response to SAMHSA’s request for feedback clearly demonstrated the field’s interest and concern about the definition and principles. The two forums combined had over 1000 participants, nearly 500 ideas, and over 1,200 comments on the ideas. Over 8,500 votes were also cast in support of the ideas on the forums. The many thoughtful comments and suggestions SAMHSA received have contributed to the final version of the recovery definition and principles presented in this document.
Overview

Despite a range of long-standing historical, political, ideological, professional, structural, and practical barriers, there has been, and continues to be, a clear consensus that integration between mental health and addiction services is sorely needed and long overdue. — (Davidson & White, 2007)

People in recovery from addictions and mental health problems met as collaborators in a formal dialogue convened by the Substance Abuse and Mental Health Services Administration (SAMHSA) to explore commonalities and differences in their experiences of recovery. The aim of the dialogue was to explore recovery as an organizing construct that could bridge concepts and practices across the mental health and addictions fields by drawing on the experience, wisdom, and expertise of people with lived experience with recovery. Throughout the dialogue, participants worked to identify similarities and differences, forge relationships, and generate recommendations for action items that would help foster and sustain integrated and holistic supports, services, and systems for people in recovery from mental health problems and addictions.

The compelling reason for this dialogue was to keep pace with the rapidly changing healthcare landscape, including changes that could affect the way services and supports for people in recovery are organized, delivered, and financed. This dialogue was an opportunity for participants to provide insights for a common understanding of recovery across mental health and addictions, and to offer recommendations for concepts, policies, and practices that will advance recovery in the new and evolving healthcare environment.
Meeting Participants and Process

Thirty-one (31) people gathered for the two-day meeting, held August 18-19, 2010. A key component of the process was the sharing of participants’ personal stories of recovery. All participants were invited to relate their experiences before and during recovery so that commonalities and differences could be discerned. Participants were assured confidentiality, and steps were taken, such as generating group consensus on meeting guidelines, to help create an environment where participants could feel comfortable and respected while sharing their stories.

To help facilitate discussion, the organizers distributed the white paper, “The Concept of Recovery as an Organizing Principle for Integrating Mental Health and Addiction Services,” written by Larry Davidson and William White, in advance of the meeting.

Dialogue Meeting Objectives

The meeting objectives were stated as the following:

- Enhance understanding, respect, and partnerships between mental health consumers and people in addiction recovery through a dialogue examining recovery from mental health problems and substance use disorders.
- Elicit participants’ ideas and suggestions regarding a working definition of recovery that describes the essential experience of those in recovery from mental health problems and addictions, as well as components and elements of a recovery-oriented system. Identify unique and/or divergent issues, along with implications for services and systems.
- Provide ideas for action steps and recommendations for further consideration by preparing and distributing a monograph describing the processes and outcomes of the meeting.
The History of the Peer Recovery Movement

“Recovery has to do with the people who have been in my life. Recovery is about support.”
— Dialogue participant

To place the dialogue meeting in perspective, participants developed a time-line of some of the important events in the development of the peer recovery movement.

- **1935.** Birth of Alcoholics Anonymous (AA) in Akron, Ohio, formed by Bill Wilson and Dr. Bob Smith.
- **1950s.** AA membership surpasses 90,000.
- **1960s.** Deinstitutionalization leads to the release of large numbers of patients from psychiatric hospitals. Many of these individuals experience great difficulty finding adequate services or supports until an ex-patient placed an ad in a California newspaper seeking people with similar mental health experiences for mutual support. This early organizing effort is pivotal in the development of the mental health consumer/peer/survivor recovery movement.
- **1970s.** Seeds are planted in mental health treatment similar to those in the 12-step programs of AA. AA membership grows exponentially, and 12-step groups are founded to help those dealing with substance addictions other than alcoholism (e.g., Narcotics Anonymous, Cocaine Anonymous).
- **1980s and 1990s.** Hundreds of support groups and organizations begin to take root to help people with mental illness. Statewide organizations in support of those with mental illness also grow, and there is a need for national consumer-run organizations. 12-step groups providing mutual aid for those addicted to alcohol and other drugs continue to grow and flourish in the U.S. and internationally.
- **1998.** SAMHSA/CSAT initiates the Recovery Community Support Program (RCSP), funding 19 grassroots groups to organize the addiction recovery community to participate
in public dialogue about addiction treatment and recovery. SAMHSA’s Treatment WORKS! public education campaign becomes National Alcohol and Drug Addiction Recovery Month supporting hundreds of addiction recovery events nationwide.

- **2001.** St. Paul Recovery Summit is held. At this meeting, Faces and Voices of Recovery (FAVOR), a national organization for recovery advocates and recovery advocacy, is formed.

- **2002.** The RCSP grant program changes its focus from recovery community organizing to design and delivery of peer recovery support services. As additional cohorts of RCSP grants are funded, efforts are ongoing to define peer recovery support services, establish their value and significance, and differentiate them from both professional treatment and mutual aid supports such as AA.

- **2003.** President Bush creates The New Freedom Commission on Mental Health, which includes consumer psychiatrist Dan Fisher among the 17 commissioners. One key idea the Commission promotes is that mental health patients can and do recover. The Commission report also promotes the integration of mental health and addiction recovery supports and services.

- **2004.** SAMHSA/CMHS convenes representatives of the field to develop the National Consensus Statement on Mental Health Recovery, along with 10 core components of recovery.

- **2005.** SAMHSA/CSAT convenes the National Summit on Addiction Recovery, where there is agreement on a set of principles of recovery and elements of recovery-oriented systems of care and from which emerges a working definition of recovery.

- **2006.** The National Coalition for Mental Health Recovery is formed. Today 30 consumer-run statewide organizations are dues paying members of the Coalition, with an office in Washington and access to power meetings.

- **2008.** The Coalition receives a grant from CMHS to prepare a history of recovery.

- **2011.** National Alcohol and Drug Addiction Recovery Month
becomes *National Recovery Month* and integrates those in recovery from mental illness along with those in recovery from substance use disorders.
Dialogue Themes and Findings

. . . *It’s not about being normal, but being more fully human, as we’re meant to be. It’s not about being mainstreamed, but about the stream being widened so the people on the fringes are part of the flow.*

– Dialogue participant

As a central process in the dialogue, participants were asked to relate their stories of recovery. Of necessity, participants had to abbreviate and simplify their accounts of what, in reality, were complex and multi-layered histories. In sharing their recovery stories, participants were asked to consider the following six points:

1. What has promoted and what has hindered your recovery?
2. What has recovery meant in your life?
3. How can the system become more oriented toward and supportive of recovery?
4. What is your understanding of the word recovery?
5. How do you understand the role of trauma in mental health problems, substance use disorders, and recovery from them?
6. What steps can be taken to ensure that recovery happens for those who need it?

Common Experiences and Themes

As participants’ stories unfolded, several themes emerged. In reflecting on the stories after all had shared, the group identified some of the key themes.

Co-Occurring Mental Health Problems and Addictions

As participants shared their life histories, a striking similarity among many of the stories was the co-occurrence of mental health problems and problematic use of substances. Although not every participant did, many reported challenges with *both* mental health issues and substance use.
**Implications for Policy and Practice:** Several participants noted the importance of providing a full range of supports and services to meet all of the individual’s needs. This could include providing greater and easier access to a full range of services, such as addiction and mental health treatment services and recovery support services, including assistance with housing, employment, education, and community connections. These services should be age appropriate, culturally congruent, and tailored to the person’s stage of recovery.

**Early Use of Substances**

Another common theme was participants’ early use of alcohol and/or other drugs. In many instances, participants related early use of substances as a response to traumatic events. Some participants also highlighted the intergenerational aspect of mental illness and addiction by noting they had been exposed, while growing up, to the substance use and mental illness of adults in their household.

A number who linked trauma and early substance use said they initially began using alcohol or other drugs in an attempt at self-soothing. One participant was particularly poignant on this theme, stating:

*I started using around 6th grade. I used substances not to feel good, but to not feel bad. There was a lot of substance-using in my family -- and violent knife and gun fights....I knew something was seriously wrong, but I didn’t know how to fix it.*

Another participant underscored the relationship between trauma in the household and early alcohol and drug use, when he shared:

*I had my first drink at 10; heroin at 15 years old... There was the trauma of seeing my mom beaten by my dad.*
Others participants reported that consuming alcohol at high levels at an early age was considered a family and community norm. As one participant noted:

*Heavy drinking was just what we did in our family, in our community, at all ages...No one thought of it as a disease or problem.*

**Implications for Policy and Practice:** Several participants noted the need to identify and intervene early in the lives of those affected by trauma by providing education and supportive services. In addition, programs that help to establish healthy norms related to non-use of addictive substances and promotion of emotional health and positive connections to supportive others can promote resiliency and protect against mental health problems and addictions.

**Centrality of Trauma in Addictions and Mental Health Problems**

The high incidence of trauma in the lives of people in recovery was underscored by participants’ stories, and most viewed trauma as part and parcel of their substance use disorder and/or mental health problems. Several participants’ stories, such as those cited above, centered on traumatic episodes they experienced or witnessed as young children or adolescents.

Other dialogue members related traumatic events across the life-span, reporting issues such as domestic violence, gang violence, war, and other physical and emotionally damaging experiences.

*I am a survivor of domestic violence and marital rape. It is the trauma that pushed me into treatment for undiagnosed depression.*

*I found a group dedicated to sexual violence and domestic violence.*

*I was in war, shot 3 times, beaten by police, thrown off a roof and left for dead...*

*I lived in a traumatized community. I grew up very afraid...*
Implications for Policy and Practice: The majority of participants noted that their recovery could have been significantly enhanced had trauma-informed supports and services been available. Moreover, several expressed concern that services and systems that were supposed to be helpful were, in fact, reinforcing experiences of trauma. Participants advocated for services that clearly acknowledge the role that trauma often plays in the development and ongoing maintenance of mental health problems and substance use conditions, and interventions that are carefully designed to address the needs of trauma survivors. This includes a fundamental shift in the design and delivery of services—from one based on asking “what is wrong with” the person to one based on understanding “what has happened” to her or him. Trauma-informed care also involves a change in orientation from traditional “top-down” environments and service delivery models to collaborative approaches that are led by consumers/survivors/persons in recovery, and in which those in recovery are supported by peers and/or professionals who honor the individual’s lived experience in decision-making about all aspects of her or his own recovery.

Several participants underscored the role of peers as supporters for those who have experienced trauma. They advocated for specialized training and ongoing support for peers working to assist others in trauma recovery.

Role and Significance of Culture

Several participants shared traumatic stories related to physical and psychological violence, discrimination, and oppression around gender, sexual orientation, race, and culture.

*I was the youngest of four siblings. I was a loving, imaginative, caring child. That changed around age five...I remember the burning crosses, white hoods. One relative was killed for teaching sharecroppers how to read... A great uncle was lynched. I moved North and went to all-white schools in Queens. Molotov cocktails were thrown into the school bus. I wasn’t welcomed in neighborhood. I fought in school and fought at home. I learned to drink and that if you were violent to others they would leave you alone.*
I was the only light-skinned sibling of 8 children and did not fit in.  
I was not black enough for blacks or white enough for whites.  

I was verbally abused and beaten [by a group of gay-bashers]…

I am a survivor of domestic violence and marital rape.  

There was cultural inhibition. The pressure to hide my Jewish culture led to self-hatred.  

I am a child of…refugees. My parents spoke no English. I went to mom’s psych appointments and had to translate, but mom wouldn’t share her real experiences and concerns. I kept to myself in high school and experience my pain alone...

**Implications for Policy and Practice:** Several participants noted that addressing cultural and social divides, including alienation and oppression around not speaking the dominant language, played a significant role in their recovery. However, many felt such perspectives were not taken into consideration in service settings. They called for careful attention to and the positive inclusion of culture in recovery efforts for those with mental health problems and substance use disorders.

Because lack of attention to cultural nuances was often highlighted as a hindrance to recovery, the dialogue underscored the need for culturally aligned, culturally appropriate, and culturally competent supports, services, and systems to help make recovery a reality for all who want and need it. For example, one participant noted that:

*I found a group dedicated to sexual violence and domestic trauma. There were 21 women around the table, and I was the only African American. Other African American women who had come didn’t stay...*
Another dialogue member explained that:

> There are entire cultures that do not even have a word for “I.” Their focus is not on the “self.” So, there is a strong need for approaches that emphasize the community, not the individual. It is important to remember that recovery is relationally-based. It is all about relationships.

This participant went on to point out that despite the fact that culture- and community-based approaches can be difficult to design and even more challenging to measure, it is important to develop approaches that focus on the collective rather than the individual in order to meet the needs of specific cultural groups.

**Many Pathways to Recovery**

Many participants recalled the precise moment or incident that triggered a breakthrough in their understanding of what was going on in their lives and what they needed to do to begin recovery. They shared many different avenues by which they found their recovery, including: formal treatment; peer recovery support services; mutual aid groups; affiliation with community and culture; connection with religion, faith communities, and/or spirituality; use (or non-use) of medications; self-care; advocacy for self and others; giving back to others and their community, and others.

> After a job injury, I went home to lie down. Oprah was on the television. Her guest facilitated a healing huddle that made me sob. It made me go to therapy and I learned what a dysfunctional family was, and how to change.

> I went into an AA meeting, heard something that resonated, and my recovery began.

> No matter the road to recovery it means health--mentally, physically, spiritually.

> Throughout life I have been helped by faith. It has to do with loving relationships you are able to forge that get you through the process.
I didn’t start recovering until I decided to tell people...I started telling my story in case there were others out there who could be helped by that. I decided I was not all those diagnoses and I got stronger. What got me through was my friends and me taking responsibility...

To take care of myself, I use NES—nutrition, exercise, sleep. I advocated for others because it was easier than advocating for myself.

One participant shared experiences of stigma and discrimination by treatment professionals and people in the recovery community because he uses medication to support his recovery:

I was discharged from the Army for heroin addiction. In 1978 I went into methadone. My boss told me to get off methadone. I was on and off methadone. I detoxed and relapsed in 2 weeks... I was made to feel weak for using methadone...

He advocated for greater understanding and acceptance of the many different paths to recovery and, especially, medication-assisted recovery from addictions.

**Implications for Policy and Practice:** Participants agreed on the importance of affirming the many pathways to recovery, based on the realization that what works for one individual may not work for another. They also noted that different pathways—and combinations thereof—may be employed at different stages of the recovery process and the life cycle. Recovery efforts that uphold the dignity, individuality, and uniqueness of each person were considered essential in promoting recovery.

Self-care practices were noted by some participants as important as a part of taking responsibility for one’s own health and well-being on a day-to-day basis. In addition, holistic health practices, such as yoga and meditation, were identified as helpful by some. Participants suggested that these wellness-oriented practices could be built into both formal
and informal service settings, including peer programs. Several participants mentioned spirituality as a source of strength for their recovery. This was variously experienced as connection to God or a higher power, affiliation with a community of faith, connection to a community or culture, or some other personal experience of the transcendent. From a policy and practice standpoint, it is important to honor faith-based and spiritually-oriented approaches to recovery, especially within a cultural context. Participants also acknowledged it is equally important to honor secular recovery paths (i.e., those that do not incorporate a faith-based or spiritual component).

**Social Support and Peer Support**

Participants were in agreement that connecting with others and experiencing support, especially peer support, can play a significant role in getting into and staying in recovery.

*Recovery has to do with the people who have been in my life. Recovery is all about support...*

For some, giving back to others also played an important role in their ongoing recovery:

*To keep it, you have to give it away...*

*Recovery means giving to others what I didn’t get.*

Some participants spoke of shame and internalized dislike of self as a result of addictions, mental health problems, and/or membership in a marginalized racial, ethnic, cultural, or social group. They noted that peer communities can serve as a powerful antidote by offering a source of positive identity and affiliation, as well as providing feelings of enhanced self-worth from being of service to and sharing recovery with others.

**Implications for Policy and Practice:** There was univocal agreement that peer services play an important and empowering role in promoting recovery. Dialogue participants advocated for increased funding for and program expansion of peer services. They also recommended more research to establish the efficacy and cost-effectiveness of peer services and to develop evidence-based practices.
Discordances and Hard Questions

The dialogue needs to grow bigger — and bigger than us.
– Dialogue Participant

Although the dialogue participants found many areas of commonality, their stories of recovery also revealed some differences. Some participants characterized the dialogue as a “meeting across cultures,” and nearly all noted the need for ongoing discussion to promote further exploration of issues raised during the meeting. Some of the “hard questions” that emerged included the following:

• Language and Terminology:

Language is important….
My grandfather’s official… birth certificate identified him as “savage.” That had an impact on me when I learned that.

Addiction not just a behavioral issue.
The biology had done damage to my brain…
How come no one told me addiction was a disease?

Well meaning people say they speak for us.
But they don’t speak for us. Only we can speak for us.

How one describes an experience both reflects and shapes the understanding of that experience both by oneself and by others. Moreover, who is privileged to name an experience becomes a critically important question in the power dynamics surrounding it. Dialogue members seemed to agree on the need to describe their own experiences in terms that are meaningful and empowering to them. However, there was less than full agreement on what actually constitutes the recovery experience.

For example, some—though not all—in the addiction recovery community have placed significant emphasis on the disease
The disease concept has evolved significantly over recent decades, particularly now that research is elucidating the neurobiological processes of addiction. Additionally, it is now well understood that addiction—like diabetes, asthma, heart disease, and other chronic conditions—results from the interplay of genetic and environmental factors such as social and cultural norms, poverty, and the availability of substances.

The disease concept has helped to shape public awareness away from a “blame the victim” mentality based on addiction as a character flaw or moral weakness toward a view of addiction as a medical condition. Additionally, the broad adoption of the disease concept has served to reduce negative views of substance use disorders by showing how they are like other chronic conditions in their etiology and progression. Moreover, the emphasis on a “medical model” in addictions treatment has been essential to the recognition of substance use disorders as medical and public health conditions that need to be effectively addressed in health care systems.

However, this way of framing addictions did not resonate well for some participants representing both the addictions and mental health recovery communities. From some members’ perspectives, the disease concept seems limiting in its failure to account for interpersonal and environmental factors—such as trauma, poverty, discrimination, social injustice, and others—that play a crucial role in the etiology and maintenance of addictions and mental health problems. Moreover, some participants expressed concern that the disease concept may inadvertently promote social exclusion. By definition, they argued, the disease concept focuses on pathology. It could be construed as emphasizing deficits and, in so doing, establish an “us” versus “them” mentality in which those with the disease of mental illness or addiction are viewed in a diminished status relative to those without the disease.

Further dialogue on language and terms will be necessary as
the different communities of recovery continue to work toward greater levels of mutual understanding and cooperation.

- **Concept of Abstinence:**
  
  In the addictions world, many view abstinence as the defining characteristic of recovery, whereas others view reduction in use as a legitimate criterion for recovery. Yet others view recovery as a process that begins before abstinence, leads to it, and that can continue when relapse occurs. In the latter view, abstinence is not the defining characteristic of recovery, but rather a key tool for achieving and maintaining it. Alcoholics Anonymous (AA), a strong support for millions of people in recovery, promotes total abstinence as a mechanism for achieving recovery. However, AA makes it clear that “a desire to stop drinking” is the only requirement for membership.

  Some individuals believe that reduced use of substances could equate to recovery for some people. However, research indicates that, for those with a substance use disorder, there is an elevated risk of relapse for the first 3-7 years of recovery (Dennis, Foss, & Scott, 2007). For this and other reasons, abstinence is considered the safest approach for those with substance use disorders.

  Within the mental health recovery community the concept of abstinence is not salient, except as related to those who may have a co-occurring substance use disorder. However, because abstinence is such an important concept in the addictions world and because it can lead to strong differences of opinion, it may serve as a barrier to finding common ground across the many cultures of recovery.

- **Use and Meaning of Medications in Recovery:**
  
  The types of medications used in mental health recovery and addiction recovery are different, and there are different psychological and social meanings attached to their usage. For example, the practice of forcing an individual to take anti-psychotic or other psychiatric medications against his or her will
carries a particular set of negative meanings and associations for many in the mental health recovery community. However, these associations are not generally part of the consciousness or culture of members of the addiction recovery community. However, for both mental health consumers and people in addiction recovery, use of medication as a route to or support for recovery has sometimes been a topic of misunderstanding and a source of contention. Some individuals who use medications — such as buprenorphine or methadone to treat addictions or medications for psychiatric symptoms — have felt marginalized in the recovery movement. They believe others have accorded them reduced standing in the community as a result of the erroneous belief that following a prescribed medication regimen is equivalent to “using” substances or because of the belief that using medications is somehow less desirable than not using medication in one’s recovery. Fortunately, attitudes are changing, and many communities of recovery are adopting a more inclusive position that embraces those pursuing recovery through many different pathways, including use of medications.

Despite advances in understanding, there is no single, agreed upon understanding of the role and meaning of medications in either the addictions recovery or mental health consumer communities. There is need for further dialogue to come to a better understanding of the highly nuanced set of issues surrounding medications and recovery.

**Concept of Coercion:**

There is legitimate concern about the perceived and actual violation of mental health clients’ civil rights in practices such as civil commitment and the use of seclusion and restraint, including chemical restraint. Protection and advocacy efforts have led to reforms related to these practices, but, unfortunately, violations to mental health consumer’s bodies, minds, and spirits continue to occur. With the realization that the majority of persons seeking mental health and addictions services are likely to have a history of trauma, the negative consequences of these practices
becomes evident. Coercive and invasive treatments cause or exacerbate feelings of threat, violation, shame and powerlessness, experiences all profoundly antithetical to healing from trauma (or to the healing process generally).

On the other hand, many individuals compelled to enter treatment for substance use disorders — for example, through diversionary programs, probation and parole, and/or through state or federal court and other recognized legal entities — experience positive outcomes similar to those who enter addiction treatment voluntarily. Moreover, fully 38% of those in specialty addiction treatment are referred through the criminal justice system, the largest referral source to specialty addiction treatment (SAMHSA, 2009). Many in the addiction recovery community who began treatment through the criminal justice system report eventually feeling grateful they were required to enter treatment because they were not able to make the best and healthiest choices for themselves while in the throes of their addiction.

The issue of coercion is one that requires further discussion as members of the mental health and addiction recovery communities strive to find common ground while respecting differences in outlook, experience, and understanding.
Dialogue Outcomes and Recommendations

Recovery Definition

The dialogue participants were asked to collaborate on a draft definition of recovery that would capture the essential experiences of those in recovery from mental health problems or addictions or both. To provide a starting point, participants reviewed consensus definitions from previous SAMHSA meetings (2004 SAMHSA/CMHS Summit on Mental Health Recovery, 2005 SAMHSA/CSAT Summit on Addiction Recovery) convened to define mental health recovery and addiction recovery. A draft definition and principles of recovery were developed at this meeting and subsequently presented to stakeholders for review, comment, and suggestions.

The SAMHSA definition and principles presented here are the current working versions that were based on – although not identical with – those developed at the Dialogue Meeting.

Recovery from mental disorders and/or substance use disorders is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

This definition aligns with SAMHSA’s Recovery Support Strategic Initiative, which promotes recovery by focusing on four major dimensions that support a life in recovery:

- **Health**: overcoming or managing one’s disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing.
- **Home**: a stable and safe place to live;
- **Purpose**: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the
independence, income, and resources to participate in society; and

- **Community**: relationships and social networks that provide support, friendship, love, and hope.

### Guiding Principles of Recovery

Dialogue participants articulated 10 guiding principles of recovery which they believed clarify and describe the essential characteristics of recovery from addictions and mental health problems. As with the recovery definition, subsequent to the Dialogue Meeting, SAMHSA sought additional stakeholder input on the guiding principles.

Following are the SAMHSA guiding principles of recovery, which are based on the draft principles developed at the Dialogue Meeting:

**Recovery emerges from hope**: The belief that recovery is real provides the essential and motivating message of a better future – that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them. Hope is internalized and can be fostered by peers, families, providers, allies, and others. Hope is the catalyst of the recovery process.

**Recovery is person-driven**: Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. In so doing, they are empowered and provided the resources to make informed decisions, initiate recovery, build on their strengths, and gain or regain control over their lives.

**Recovery occurs via many pathways**: Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds including trauma experiences that affect and determine their pathway(s) to recovery. Recovery is built on the multiple capacities, strengths, talents, coping abilities, resources, and inherent value of each individual. Recovery pathways are highly personalized. They may
include professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches. Recovery is non-linear, characterized by continual growth and improved functioning that may involve setbacks. Because setbacks are a natural, though not inevitable, part of the recovery process, it is essential to foster resilience for all individuals and families. Abstinence from the use of alcohol, illicit drugs, and non-prescribed medications is the goal for those with addictions. Use of tobacco and non-prescribed or illicit drugs is not safe for anyone. In some cases, recovery pathways can be enabled by creating a supportive environment. This is especially true for children, who may not have the legal or developmental capacity to set their own course.

**Recovery is holistic:** Recovery encompasses an individual’s whole life, including mind, body, spirit, and community. This includes addressing: self-care practices, family, housing, employment, education, clinical treatment for mental disorders and substance use disorders, services and supports, primary healthcare, dental care, complementary and alternative services, faith, spirituality, creativity, social networks, transportation, and community participation. The array of services and supports available should be integrated and coordinated.

**Recovery is supported by peers and allies:** Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Peers encourage and engage other peers and provide each other with a vital sense of belonging, supportive relationships, valued roles, and community. Through helping others and giving back to the community, one helps one’s self. Peer-operated supports and services provide important resources to assist people along their journeys of recovery and wellness. Professionals can also play an important role in the recovery process by providing clinical treatment and other services that support individuals in their chosen recovery paths. While peers and allies play an important role for many in recovery, their role for children and youth may be slightly different. Peer supports for families are very important for children with behavioral health problems and can also play a supportive role for youth in recovery.
Recovery is supported through relationships and social networks:
An important factor in the recovery process is the presence and involvement of people who believe in the person’s ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change. Family members, peers, providers, faith groups, community members, and other allies form vital support networks. Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles (e.g., partner, caregiver, friend, student, employee) that lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation.

Recovery is culturally-based and influenced:
Culture and cultural background in all of its diverse representations — including values, traditions, and beliefs are keys in determining a person’s journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual’s unique needs.

Recovery is supported by addressing trauma:
The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues. Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.

Recovery involves individual, family, and community strengths and responsibility:
Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for themselves. Families and significant others have responsibilities to support their loved ones, especially for children and youth in recovery. Communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and
recovery. Individuals in recovery also have a social responsibility and should have the ability to join with peers to speak collectively about their strengths, needs, wants, desires, and aspirations.

Recovery is based on respect: Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems – including protecting their rights and eliminating discrimination – are crucial in achieving recovery. There is a need to acknowledge that taking steps towards recovery may require great courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in one’s self are particularly important.

**Recommendations for Advancing the Concept of Recovery and the Integration of Mental Health and Addiction Recovery Services**

Dialogue participants were asked to generate concrete suggestions to promote enhanced coordination and integration of mental health and addictions recovery services and, more generally, to advance the concept of recovery.

**General Suggestions**

Participants began by offering some general suggestions to move the concept of recovery forward and promote recovery support services. These recommendations include the following:

- Use strength-based language when discussing recovery and people in recovery from addictions and mental health problems.
- Identify and use multiple methods to get the message out that recovery is possible, that people can and do recover.
- Promote and fund consumer drop-in centers, peer-run wellness centers, and peer-run recovery community centers. These are effective methods that provide a sanctuary in the community for people to find recovery. These centers function as a hub for peer-based services and supports, a place where recovery can be grounded in a community setting.
- Peer leadership should be a part of policy, practice, and workforce development at all levels.
It is important that we do not forget or minimize the role of social determinants, such as poverty, cultural oppression, and social injustice, in all health disparities, including addictions and mental health problems.

Specific Recommendations

Conceptualization, Organization, and Financing of Integrated Recovery Services

- As steps are taken to integrate mental health and addictions recovery, it is important that the unique features and distinctive characteristics of each culture and community be honored at the same time that commonalities are identified and aligned.
- Any new behavioral health model that integrates mental health and addictions should keep recovery — not illness or disease — as the central organizing construct. At the same time, promote the adoption of effective treatment and recovery support services by emphasizing that behavioral health is part of overall health.
- Provide a voice for consumers and peers in all aspects of service design, delivery, and evaluation.
- SAMHSA should develop national standards – or promote the development of national standards – for peer recovery services and/or peer-run recovery programs so that services and programs can be reimbursed on par with treatment services.
- SAMHSA should ensure that Block Grant funds are used to pay for peer recovery support services and consumer-operated services.
- SAMHSA should allocate resources for the evaluation of peer services and the development of evidence-based practices.
Workforce Development

- SAMHSA should include peer and consumer workforce issues in all workforce development initiatives.
- SAMHSA should define core competencies for peer recovery coaches, peer specialists, and similar workers.
- SAMHSA should provide a state-by-state listing of credentialing requirements for recovery support specialists, peer recovery coaches, and other consumer/peer workers, as well as accreditation requirements for peer- and consumer-operated recovery community organizations.
- SAMHSA should develop and provide training for peer supervision emphasizing that peers should supervise peers, and should provide training on other related topics such as ethics for peer/consumer services and self-care for peer specialists and peer recovery coaches.
- SAMHSA should train all members of the workforce in recovery and recovery-based approaches.

Peer/Consumer Recovery Support Services

- SAMHSA and other agencies should direct funding toward peer services and consumer-run programs. Funds should be directed toward direct services, as well as toward efforts to build the capacity of grassroots communities of people in recovery through activities such as promoting coalitions, developing competencies, and building infrastructure.
- SAMHSA should continue to encourage, support, and fund programs that promote health and wellness to combat the early mortality of people with mental health problems and addictions (who die decades earlier than those without these conditions), including peer programs to address holistic health and wellness.
- SAMHSA should give more attention to youth peer-to-peer programs, services, and initiatives.
Recovery Research

- SAMHSA should convene a meeting on developing a measure (or measures) of recovery. Researchers, including consumer/peer researchers and empowerment researchers with expertise in cultural issues, should be included. Both qualitative and quantitative measures should be considered.

- SAMHSA should partner with NIH (NIMH, NIAAA, NIDA) to build and/or strengthen the empirical research base demonstrating the efficacy and cost-effectiveness of recovery centers, drop-in/wellness centers, and other peer/consumer recovery support services. More specifically, SAMHSA should convene a group of researchers, including peer/consumer researchers, along with federal staff of NIH to develop a comprehensive research agenda on peer recovery support services.

- SAMHSA should work with NIH (NIMH, NIDA) to promote additional research to identify best practices and emerging practices in substance abuse prevention and mental health promotion.

- SAMHSA should continue to promote adoption and implementation of evidence-based treatment approaches and should develop evidence-based practices for peer services.

Recovery Materials

- SAMHSA should provide recovery-oriented materials in languages for underserved populations.

- SAMHSA should develop and disseminate materials for diverse groups (based on age, gender, race, culture, and ethnicity). These materials should emphasize hope, peer support, and recovery, and should be in formats that appeal to different demographic groups (e.g., by using translations, graphics, comics, and new technology).

- SAMHSA should develop materials and training for providers throughout the workforce continuum on how to develop recovery plans (versus treatment plans). There are “recovery capital assessments” and recovery plans that have been developed by
people in recovery that could be used as models for this.

- SAMHSA should continue to develop, promote, and disseminate information appropriate to all audiences on trauma-informed supports, services, and systems. This should include curricula, train-the-trainer models, online courses, fact sheets, and other materials for people in recovery, peer specialists, providers, policy-makers, administrators, and others.

**Promoting Partnerships that Support Recovery**

- SAMHSA should convene a dialogue with representatives of law enforcement, criminal justice, mental health, and addictions recovery to discuss issues related to the nexus of these fields and to educate law enforcement and criminal justice personnel on trauma and its relation to mental illness and substance use disorders.

- SAMHSA should partner with Department of Veterans Affairs and help promote peer support services for veterans.

- SAMHSA should convene a dialogue on prevention of addictions and mental illness and promotion of overall wellness. In addition to people in recovery, youth and family members should be involved. Issues related to substance abuse prevention and mental health promotion, as well as wellness promotion generally, should be included in the dialogue.

**Cultural Issues**

- SAMHSA should promote a broad range of culturally-based healing and recovery approaches.

- In examining issues related to recovery, there is a need to address historical/cultural trauma, including processes for truth and reconciliation.

- SAMHSA should develop and disseminate materials, training packages, and training (face-to-face and online) regarding culturally congruent and culturally competent supports and services that are recovery-oriented.
Summary and Conclusion

The Recovery Dialogue Meeting provided an opportunity for people representing the addictions and mental health consumer recovery communities to talk together in an effort to explore their commonalities and differences. The dialogue provided an opportunity for participants to share their stories so that key themes could be discerned that would capture the essential experience of recovery for people with addictions and mental health problems. It was hoped that the deliberations from the dialogue would ultimately inform a framework for better coordination of mental health and addiction recovery services, as well provide concrete recommendations for SAMHSA.

Some dialogue members expressed frustration with the timeframe for the dialogue, saying there was insufficient time to develop trust and comfort with people they were meeting for the first time. Others felt pressured to condense their story of recovery into an abbreviated format, as was necessary for this meeting. Still others said they were challenged to find common ground across cultural divides with people they did not know before the meeting.

Despite these difficulties, the participants were productive in discerning key themes from their recovery stories that led to the development of a draft definition of recovery and a set of guiding principles that further elaborate the experience of recovery from addictions and mental health problems. The dialogue participants also generated a number of useful recommendations that can influence the federal agenda in ongoing efforts to advance recovery.

Beyond the immediate outcomes from this dialogue meeting, it is hoped that the process will encourage ongoing collaboration between and among the diverse cultures of recovery represented by the dialogue participants. To the extent that those in recovery continue to find common ground while respecting their differences, they can influence, advocate for, and provide increased opportunities and avenues for recovery for themselves and others, so that all who seek recovery can achieve it.
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**Allegra Bennett of Westover Consultants reported the meeting and prepared a draft report.