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Realizing Recovery: the U.S. Substance Abuse and Mental Health Services Administration's Efforts to Foster Social Inclusion

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Article abstract

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Abstract

For nearly 20 years, the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) has fostered social inclusion for Americans with mental and/or substance use disorders. SAMHSA has done this by promoting the recovery paradigm, an approach predicated on a positive, strength-based, and person-centered view of those with behavioral health conditions. SAMHSA has provided leadership by promoting policies, programs, practices, and public awareness initiatives that advance recovery, recovery support services, and recovery-oriented service delivery systems. SAMHSA's approach has been participatory, engaging a variety of stakeholders, and comprehensive, focusing on multiple strategies in targeted priority areas.

Keywords : SAMHSA, recovery, recovery movement, mental health recovery, addiction recovery, recovery support services, self-determination, social inclusion

Résumé

Depuis presque 20 ans, *the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA)* a favorisé l'inclusion sociale des États-uniens ayant des troubles de santé mentale ou de consommation de substances. SAMHSA a fait la promotion du paradigme du rétablissement, une approche positive et centrée sur la personne ayant des troubles de comportement et prenant en considération ses forces. SAMHSA s'est avéré un leader en la matière, fournissant des politiques, des programmes, des pratiques et des initiatives de sensibilisation du public facilitant le rétablissement, les services de soutien au rétablissement, et les systèmes de prestation de service liés au rétablissement. L'approche de SAMHSA est participative, engageant une série d'acteurs, et globale, se concentrant sur des stratégies multiples dans des domaines prioritaires.

Mots-clés : SAMHSA, rétablissement, mouvement en faveur du rétablissement, rétablissement en santé mentale, rétablissement dans le champ des dépendances, services de soutien, autodétermination, inclusion sociale

The recovery movement in mental health and addictions has its origins in the United States, where it emerged from the lived experiences of individuals with these conditions. The recovery movement focuses on self-determination, self-help, and self-empowerment.

Social change movements such as the recovery movement do not operate in isolation, but are embedded in political and societal contexts. One key factor in the success of such movement is the extent to which governments support or inhibit such movements for change. This article examines the efforts of one U.S. governmental agency – the Substance Abuse and Mental Health Services Administration (SAMHSA) – and how it has affected the growth and development of the recovery movement in mental health and addictions over the past twenty years.

SAMHSA's has defined recovery from substance use and/or mental disorders as a:

> *process of change through which individuals improve their health and wellness, live self-directed life, and strive to reach their full potential* (DHHS/ SAMHSA/CMHS, 2012).

Emphasizing quality of life and self-direction, his definition, along with the guiding principles discussed below, reflects the core themes of the recovery movement.

Background

SAMHSA was established in 1992 to provide a Federal focus on mental health and substance use disorders services in the U.S. government. It is one of eleven agencies in the U.S. Department of Health and Human Services.

SAMHSA was created from several other agencies – most notably the Alcohol, Drug Abuse and Mental Health Administration, which housed the National Institute for Mental Health (NIMH). SAMHSA's was created, in part, to separate research on mental and substance use disorders from support for service delivery for these conditions.

Prior to SAMHSA's inception, the U.S. government's support for the recovery movement was sporadic. However, despite the lack of a systematic approach, the U.S. government did support activities related to recovery, and these helped to set the stage and provide the foundation for SAMHSA's efforts in support of recovery.

The first federal initiative focused on recovery was the Community Support Program (CSP) in the NIMH in the 1970's. Designed to support people with serious mental illness to live outside of institutions, the CSP focused on the need to provide a comprehensive array of supports and services, including peer support.

In the early 1980's, NIMH/CSP began funding technical assistance to expand peer support activities. This led to support for the first *Alternatives* Conference in 1985 – a national training event for mental health consumer leaders. Over 20 years later, SAMHSA continues providing support for this conference that attracts up to 1,400 individuals annually (DHHS/ SAMHSA/CMHS, 2008).

The Protection and Advocacy for Mentally Ill Individuals Act of 1986 (Public Law 99-319) established a Federally-supported system to investigate allegations of abuse and neglect in facilities serving people with mental illnesses. This was the first legislation that mandated consumer involvement on the advisory bodies of programs funded via this system.

In the late 1980's, NIMH/CSP funded several demonstration programs to evaluate service programs operated by consumers. This included a multisite program that examined consumer-operated case management programs, drop-in centers, and other models (Van Tosh & del Vecchio, 2000).

In the early 1990s, SAMHSA initiated the Treatment Works campaign, which later became National Alcohol and Drug Addiction Recovery Month (1998) and subsequently Nation-

al Recovery Month (2011). National Recovery Month facilitates social inclusion by involving millions of individuals, families, government and civic organizations, the business sector, healthcare workers, the justice sector, and elected and appointed officials in celebratory events, policy and educational forums about recovery, and the contributions of people in recovery. These activities promote social discourse about the need to support individuals in recovery by tackling discriminatory practices and negative public perceptions about those in need of services and/or in recovery.

In 1998, SAMHSA's Center for Substance Abuse Treatment initiated the Recovery Community Support Program (RCSP), its first systematic effort to reach out to and engage the addiction recovery community in the public dialogue on addiction treatment and recovery. Early RCSP grantees worked to organize the recovery community, raise awareness of the reality of recovery, provide public education, and provide input into policies and services for people with addictions or in recovery. In 2002, the program shifted from a focus on recovery community organizing to the design and delivery of peer-to-peer recovery support services for with addictions.

SAMHSA's Approach

Building on these efforts, SAMHSA has provided leadership by promoting policies, programs, practices, and public awareness initiatives that advance recovery, recovery support services, and recovery-oriented service delivery systems. SAMHSA's approach has been both *participatory,* involving numerous stakeholders, and *comprehensive*, involving multiple strategies in targeted priority areas.

Paradigmatic change necessitates wholesale modification of the vision, values, practices, and power dynamics around which multiple systems, organizations, and individuals organize and from which they operate. Vested interests and existing operating procedures can be significant barriers to change. A participatory approach that engages multiple participants helps to promote the intended change.

Core recovery principles also necessitate a participatory approach. The principles of self-direction, responsibility, and empowerment speak to the significance of people having a voice in the systems and organizations that affect their lives. This includes, in particular, the meaningful participation of people who live with mental health and/or addiction problems. The democratically-based ideas of the U.S. government function as another key driver for a participatory approach.

SAMHSA's efforts to engage stakeholders in transformation efforts include:

- *National Advisory Council*: SAMHSA is required by legislation to convene standing councils comprised of external stakeholders, including consumers/people in recovery, to advise the agency on its direction and activities;
- *Special Meetings*: SAMHSA convenes regional consumer meetings, as well as roundtable dialogue meetings between consumers/ people in recovery and other groups to help promote recovery;
- *Grants*: By law, SAMHSA requires states to convene planning and advisory councils composed of stakeholders, including consumers/ people in recovery, to receive annual formula block grants. SAMHSA includes language in grant announcements that require the participation of consumers/people in recovery;
- *Strategic Initiatives*: SAMHSA recently identified eight (8) strategic initiatives to focus agency activities, including one on Recovery Supports. In identifying these priorities, SAMHSA solicited the participation of many stakeholders, including the use of on-line voting and discussion boards to expand participation;
- *Staffing*: In 1995, SAMHSA hired its first self-identified consumer to help foster recovery-based efforts. Since that time, agency hiring efforts have expanded.

Systems transformation also requires the strategic targeting of multiple areas. SAMHSA's efforts have included:

- *Theory*: to help define and clarify the vision of recovery;
- *Policy*: to establish guidelines for promoting recovery;
- *Practice*: to identify protocols for providing recovery-based services and supports;
- *Measurement*: to identify and monitor individual and systems indicators to determine progress in promoting recovery;
- *Public Awareness*: to educate and engage target audiences to foster transformation.

- *Theory: Building a Framework for Recovery and Recovery-Oriented Practice*

SAMHSA has worked with stakeholders to develop definitions, values, and principles of recovery for those with mental and substance use disorders. In 2004 and 2005, SAMHSA's Center for Mental Health Services (CMHS) and Center for Substance Abuse Treatment (CSAT), respectively, convened national meetings of stakeholders, including mental health consumers, people in addiction recovery, family members, providers, advocates, researchers, State and local officials, and others. At the CMHS meeting, participants achieved consensus on a definition and guiding principles of mental health recovery (DHHS/SAMHSA/CMHS, 2006). The CSAT meeting resulted in a definition, guiding principles, and elements of a recovery-oriented system for those with addictions (DHHS/SAMHSA/CSAT, 2007).

Following these meetings, significant gains have been made to integrate recovery principles into services for those in recovery from mental health problems and addictions.

However, even though mental and substance use disorders often co-occur in the same individual, addictions and mental health services in the U.S. have often been organized, delivered, and financed in "silos" that do not always correspond with the realities of people's lives.

To support greater collaboration between the mental health and addiction recovery fields, SAMHSA convened a Dialogue Meeting in August 2010 to explore commonalities and differences in the lived experience of recovery for people with mental and substance use disorders. At the 2010 Dialogue Meeting, participants developed a draft definition of recovery from substance use and/or mental disorders, along with 10 guiding principles of recovery.

Between August 2010 and August 2011, SAMHSA elicited stakeholder comment on the draft definition through discussions, meetings, and a formal public conducted via the SAMHSA Feedback Forum. SAMHSA received comments from over 1,000 participants, with nearly 500 ideas, over 1,200 comments on the ideas, and over 8,500 votes cast in support of the ideas on the forums.

SAMHSA carefully considered all stakeholder comments and prepared a working definition of recovery that was posted on the SAMHSA blog in December 2011. A slightly revised version was later posted on March 23, 2012, as follows:

> 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 (DHHS/SAMHSA/CMHS, 2012a).

SAMHSA also delineates 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 no prescribed medications if one has an addiction problem - and for everyone in recovery, making informed, health 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;

- *Community*: relationship and social networks that provide support, friendship, love and hope (DHHS/SAMHSA/CMHS, 2012a).

SAMHSA's 10 guiding principles of recovery further elaborate on the meaning of recovery for those with mental and substance use disorders:

- Guiding Principles of Recovery

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 relationship 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.

SAMHSA has developed this working definition of recovery to help policy makers, providers, funders, peers/consumers, and others design, measure, and reimburse for integrated and holistic services and supports to more effectively meet the individualized needs of those with mental health problems and addictions.

Recognizing the importance of engaging youth and young adults in a similar dialogue, SAMHSA convened a meeting in December 2010, bringing together 38 young people in recovery to gather their perspectives on needed supports for their recovery. The participants identified several distinct needs, most notably the need for peer support and for the promotion of positive social norms for youth in recovery. A sector of this core group of young people in recovery have formed a loosely-knit leadership group self-titled "Young People in Recovery."

SAMHSA is disseminating the definition and principles to the behavioral health Field and other key audiences to assist in the design, delivery, and financing of recovery supports and services. SAMSA will assist States, providers, and others to adopt and implement the definition through technical assistance.

Policy: Setting the Standards for Recovery

During the past two decades, national public policies have exerted influence on the realization of recovery and promotion of social inclusion for those with substance use and mental disorders:

- The *Americans with Disabilities Act* of 1990 legislated that discrimination on the basis of disability, including mental disability, is not acceptable or legal (Senate (S.) Bill 933-101st Congress: The Americans with Disabilities Act of 1990, 1989).
- The 1999 *Surgeon General's Report on Mental Health* identified the emergence of a "new recovery perspective… supported by evidence on rehabilitation and treatment, as well as the by the personal experiences of consumers" (DHHS/Surgeon General, 1999).
- In the *Olmstead Decision,* the U.S. Supreme Court ruled in 1999 that people with disabilities have a right to live in communities rather than institutions (Olmstead, 1999).
- The 2003 release of *The Final Report of the President's New Freedom Commission on Mental Health* called for the transformation of mental health care to a system where recovery was the expected goal and outcome for all who use services.
- The 2006 Institute of Medicine report, *Improving the Quality of Health Care for Mental and Substance-Use Conditions,* endorsed recovery-based approaches including supporting patients' decision-making abilities and preferences (Institute of Medicine, 2006).
- The 2007 *State Medicaid Director Letter on Peer Delivered Services* established guidance on how to bill for peer-operated services (Smith, 2007).
- The *Mental Health Parity and Addiction Equity Act of 2008* legislated equal insurance benefits for mental health and substance use and medical/surgical services (House of Representatives (H.R.) Bill 1424—110th Congress: Emergency Economic Stabilization Act of 2008, 2007).
- The *Affordable Care Act of 2010* (Public Law 111-148 – 111th Congress: Patient Protection and Affordable Care Act, 2010) proposed the expansion of health insurance coverage and mandated further parity of mental health and addiction services.
- SAMHSA's 2011 *Leading Change: A Plan for SAMHSA's Roles and Actions 2011-2014* which includes "Recovery Supports" as one of eight (8) agency initiatives and identifies the domains of "health, home, purpose, and community" as key for recovery (DHHS/SAMHSA, 2011).

Practice: Changing the Way Services Are Delivered

SAMHSA has helped change the way mental health and addiction services are delivered by focusing on peers as providers, retooling the existing workforce, and developing innovative resources and tools.

Peer Service: Over the past 20 years, SAMHSA has promoted the adoption of services provided by those in recovery. Peer services are based on the notion that individuals with the lived experience of recovery possess a unique and valued knowledge and expertise on achieving recovery they can offer to others. Building on the strengths and resiliency of people in recovery, these services are inherently optimistic, modeling the possibilities of recovery and exemplifying the reality of a healthier and more satisfying life.

Among the array of peer services for consumers/people in recovery, Wellness and Recovery Centers may be the most common form of peer-led programs. Self-help and mutual aid groups are also common, as are recovery coaching, telephone support ("warm-lines"), telephone recovery checkups, independent living programs, drug-free transitional housing, peer-led case management, vocational assistance, crisis support/respite, and assistance with benefits acquisition. Many peer-operated service programs also engage in advocacy to promote better access to services and to reduce discrimination.

SAMHSA has provided leadership and support to the ongoing development of consumer/peer-operated service programs. For example, the SAMHSA-funded State Consumer Networks enable individuals in recovery to develop and operate peer organizations to help transform local and state systems.

SAMHSA's Recovery Community Services Program (RCSP) is organized around a framework of social support, drawing on the work of House (1981), Salzer (2002), and others to identify four types of support: emotional, informational, instrumental, and affiliational. Examples include: peer mentoring and peer coaching (emotional support); peer-led relapse prevention groups; job readiness training; wellness training (informational support); child care; transportation; help accessing community services (instrumental support); recovery centers; alcohol and-drug-free socialization (affiliation support) (DHHS/SAMHSA/CSAT, 2009).

Peer services for those in recovery from mental and substance use disorders are predicated on values and principles such as the following:

- respect for the many varied pathways to recovery;
- emphasis on strengths and resources versus deficits and pathology;
- focus on person-centered planning and service delivery;
- empowerment and self-determination;
- inclusiveness and cultural diversity;
- leadership development and advocacy for the consumer/recovery community.

Often called peer specialists or recovery coaches, individuals with lived experience assist other consumers/peers in their journeys of recovery. Almost all states have or are in the process of developing programs to include peer providers into the behavioral health workforce.

To help ensure the quality of service, individual certification processes for peer specialists and recovery coaches have been developed. Certification also provides training and facilitates the billing and reimbursement for peer services. A trade group, the National Association of Peer Specialists, has been formed to help develop this new profession.

Faces and Voices of Recovery, a national advocacy organization for the addiction recovery community, along with various stakeholders, is exploring the possibility of accrediting peer recovery support service programs. The accreditation process would help assure that organizations providing peer recovery support services meet minimum standards developed in concert with the field.

Workforce Development to Support Recovery: The promotion of recovery in the behavioral health field necessitates new skills, knowledge, and abilities for the workforce that serves individuals with mental health and/or addiction problems.

First and foremost, all workers – professional, nonprofessional, paid, volunteer – must fully understand and embrace the recovery orientation. For some, this involves a fundamental shift in thinking - away from a problem/deficit focus toward a strength-based focus on recovery. Workforce development efforts are needed to promote greater understanding of the recovery paradigm and the policies and practices that emanate from it.

SAMHSA has developed trainings, technical assistance, publications, and other resources to raise the awareness of State and local officials, systems administrators, providers, and others regarding the meaning, value, and implementation of recovery and recovery-oriented approaches. In one effort, SAMHSA collaborated with the U.S. Office of National Drug Control Policy (ONDCP) to convene a September 2010 Summit on Recovery for those with addictive disorders and co-occurring substance and mental disorders. The ONDCP/SAMHSA Summit brought together stakeholders to develop concrete steps to advance recovery policies and practices.

SAMHSA also leads efforts to train behavioral health professionals about recovery through several of its programs and initiatives. The Addiction Technology Transfer Centers (ATTC) Program supports a network of training centers across the U.S. that develops, delivers, and disseminates training curricula, online courses, publications, and other resources about recovery. In addition, the ATTC Network has trained facilitators throughout the U.S. who are equipped to assist States in planning efforts to adopt and implement recovery-oriented approaches.

SAMHSA's Recovery to Practice program is working with six national organizations to develop in-depth curricula on recovery, customized to the needs of learners in their specific disciplines (psychiatry, psychology, social work, psychiatric nurses, peer specialists, addictions counselors). Through the Partners for Recovery Initiative, SAMHSA is disseminating information and resources about recovery to a wide array of stakeholders, including the behavioral health workforce, on topics such as the financing of recovery support services and strategies for advancing recovery-oriented systems of care. In addition, SAMHSA is currently developing an on-line curriculum that introduces basic recovery concepts and practices and is targeted to a wide audience.

In 2011, SAMHSA launched a new initiative, Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS), to assist States, counties, and other systems, as well as providers, consumers/people in recovery, family members, and other stakeholders, to adopt and implement recovery-oriented services and supports across the U.S. BRSS TACS convenes expert panels, conducts policy academies, presents training webinars, provides technical assistance, and develops online materials and resources on leading-edge recovery policies, practices, and services.

Shared Decision-Making Tools: Person-centered planning and consumer empowerment are central values underlying recovery-oriented services. These values have been operationalized in shared decision-making (SDM) resources SAMHSA has developed that promote client empowerment and informed choice. SDM is an interactive and collaborative process between individuals and their health care providers that is used to help make decisions pertinent to an individual's recovery. SDM tools promote enhanced collaboration between professionals and consumers and enable consumers to acquire useful information about options that could support their recovery.

SAMHSA recently released an on-line decision aid on anti-psychotic medications (DHHS/ SAMHSA/CMHSA, 2012b). In addition, SAMHSA is currently developing a second decision aide on the use of medications to support recovery from opioid dependence. Possible topics for future share decision-making tools include anti-depressants, psychosocial and behavioral therapies, complementary approaches, and psychiatric medications for children.

SAMHSA is also developing guides on person-centered planning to assist in identifying life goals and strategies for achieving these. These guides are designed for consumers/ people in recovery, providers, administrators, and family members and exemplify the values and principles of recovery.

Measurement

SAMHSA's data collection approach has helped to measure and monitor the effectiveness of recovery-based approaches, including the identification of outcome measurements and performance indicators for systems, organizations/programs, and individuals. Evaluations are conducted to study program effectiveness and identify the evidence-base of efforts to promote recovery. These data collection efforts range from simple customer satisfaction questionnaires to complex randomized controlled studies. Limitations due to methodological approaches – often as a result of resource availability – can affect the validity and reliability of findings.

SAMHSA conducted a multi-site evaluation of 13 consumer-operated programs across the country. Results showed that peer-led services

led to increases in social skills, decreases in inpatient services, and improvements in self-confidence of consumers/survivors (Van Tosh & del Vecchio, 2000).

SAMHSA also sponsored a randomized, controlled study to test the efficacy of peer-operated services as an adjunct to traditional services. This $20 million, 5-year study demonstrated that peer-operated programs enhance the well-being of those served. Based on these findings, a SAMHSA evidence-based toolkit has been developed to expand the adoption of such efforts.

To examine systems, SAMHSA supported the development of the Recovery Oriented Service Indicators (ROSI), and to measure facilities, SAMHSA supported the Mental Health Statistics and Improvement Program Consumer-Oriented Report Card. In addition, measurement efforts have examined recovery on an individual basis through program data from SAMHSA's Mental Health Transformation State Incentive Grant and the RCSP grants.

SAMHSA's National Outcome Measures (NOMS) examine key recovery-based measures of grant programs funded, including performance indicators related to housing, employment, and social supports. Most recently, SAMHSA, with stakeholder input, is developing a quality of life measure that will be piloted tested with a sample derived from SAMHSA-funded grant programs.

Public Awareness

To be effective, social transformation efforts must change hearts as well as minds. Negative public attitudes, beliefs, and prejudices (otherwise known as stigma) have been identified as the single greatest barrier to recovery. SAMHSA-supported public surveys have identified that only one in four Americans believe that recovery is possible (DHHS/SAMHSA/CMHS, 2007). Other data show that the public continues to exclude people in recovery in employment, housing, and social supports.

Over the past two decades, SAMHSA has taken a strategic approach to addressing this concern, the activities that include the following:

- *Recovery Month*: For 22 years, the National *Recovery Month* observance (www.recoverymonth.gov) has been a catalyst for social inclusion and support for those in recovery. Each year, millions of individuals, families, government and civic organizations, the business sector, healthcare workers, the justice sector, and elected and appointed officials participate in celebratory events and educational forums about recovery and the contributions being made by those in recovery. Through these activities, the recovery community in the behavioral health field recounts their stories of success, presenting a framework from which to draw references of the success of addiction treatment and mental health services and support. In 2011, Recovery Month events were also observed in 5 other countries - Bahamas (Nassau), England (Hertfordshire), Germany (Berlin), Canada (Toronto), and Wales (Cardiff).

- *Campaign for Social Inclusion*: A multi-media social marketing effort with several target audiences. A series of multi-cultural materials have been developed for young adults aged 18-25 who have friends with mental illnesses encouraging them to support their friends (www.whatadifference.samhsa.gov). Materials targeted to newly expectant parents raise awareness of the linkage between trauma and mental and addictive disorders, and encourage parents to break the cycle of trauma. A campaign for employers encourages them to recruit and retain individuals with these conditions. Other efforts include:

    - *Voice Awards:* An annual event designed to recognize recovery-based television and film productions, along with consumers/people in recovery who have promoted social inclusion in their states and local communities (www.voiceawards.samhsa.gov).

- *ADS Center:* The SAMHSA Resource Center to Promote Acceptance, Dignity and Social Inclusion (ADS Center) provides technical assistance to further social inclusion of people with mental health and/or addictions problems (www. promoteacceptance.samhsa.gov). This effort also provides support to local and state consumer groups to undertake such efforts.
- *Wellness Initiative:* This effort encourages individuals and organizations to undertake efforts to reduce the high rates of early mortality and co-morbid health conditions experienced by people with mental health and/or addiction problems (http://promoteacceptance.samhsa.gov/10by10).

Discussion

National governments can be integral players in social change efforts to foster recovery. This requires visionary leaders who recognize the potential benefits that such an approach can have both in terms of reduced disability experienced by populations, as well as lowered economic costs. The recovery movement has taken different forms throughout the world. It seems to have taken hold particularly in English-speaking countries, including Canada, the United Kingdom, Australia, and New Zealand. The Canadian Mental Health Commission formally adopted recovery as the overarching aim of mental health services in Canada in 2010, and currently is involved in numerous projects to develop and disseminate recovery-oriented practices, including a prominent anti-stigma and discrimination campaign and a major supported housing initiative. The Royal College of Psychiatrists has endorsed recovery as the vision to guide mental health service development for the foreseeable future for all of the United Kingdom, and has since developed formal policy statements and a variety of materials to guide practice. Within the United Kingdom, significant steps have been taken to adapt Wellness Action Recovery Planning for British citizens, to transform mental health organizations to a recovery orientation, and to align psychiatric practice, especially medication prescribing and administration, with this vision. Peer support has been developed in Scotland, and England, Wales, and Ireland are beginning to experiment with peer support at this time. Of interest through the United Kingdom is the Voice Hearers Network and the development of new, alternative strategies for managing auditory hallucinations.

New Zealand was the first country to develop recovery-oriented competencies for practitioners, and has developed extensive peer support networks and incorporated culturally responsive programs for Maori persons. Australia has recently issued a recovery-oriented practice framework that attempts to re-orient traditional and clinical services to the vision that was developed there largely through the peer support and rehabilitation components of their system. Australia is about to host it First Annual Recovery Forum, which indicates that the government is interested in pushing transformation to the next level, to penetrate the more traditional service sector (Le Boutillier et al, 2011).

Such systems change requires not only a “top down,” but also a “bottom up” approach. It requires participation and leadership by and from those who experience these conditions themselves. Governments can assist in identifying, developing, and investing in this leadership.

Additionally, efforts to promote recovery must include attend to the specific cultural beliefs and practices of various populations. The Western emphasis on individualized approaches may be incongruent with the focus on the family and community at the heart of other cultures. How can the tenets of recovery fit into these belief systems and the practices be adapted for different cultures? What role can national governments play in addressing these issues?

Another issue relates to the growing trend to integrate mental health and addiction services into primary healthcare systems. This trend, growing rapidly in the U.S., can help to address the high rates of early mortality and co-morbidity experienced by people with mental health and addiction problems. How can recov-

ery principles and practices be integrated into primary care systems? How can primary care staff be trained on recovery-oriented approaches? How can financing approaches encourage recovery practices in primary care settings?

A final issue is the role that information technology can play in promoting recovery. Social media, cell phone applications, on-line bulletin boards, telehealth, and other mechanisms can and are being used to promote recovery-based concepts. How can national governments foster increased use and adoption of these technologies?

Conclusion

National governments can play key roles in promoting recovery in mental health and addictions. As SAMHSA has demonstrated, this includes the need for a sustained, participatory, multidimensional effort that combines theory development, policy, peer services, workforce development, measurement, and public awareness. These efforts help to introduce and frame national discourse about these important issues. Acceptance and social inclusion for those in recovery from behavioral health conditions has been proven to be beneficial in the provision of resources to address these serious national concerns.

Our world and our nations are undergoing rapid change. Global economic downturns, war, disasters, violence, and social upheaval are known social determinants of mental health and addiction problems and corresponding disability.

Recovery offers hope - hope for people with mental illnesses and addictions. By promoting recovery, governments can be the purveyors of that hope.

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