

Designing a Recovery-Oriented Care Model for Adolescents and Transition Age Youth with Substance Use or Co-Occurring Mental Health Disorders



REPORT FROM CSAT/CMHS/SAMHSA CONSULTATIVE SESSION NOVEMBER 13-14, 2008

SEPTEMBER 2009

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Executive Summary

Purpose and Approach

On November 13 and 14, 2008, the Substance Abuse and Mental Health Services Administration (SAMHSA) and its Center for Substance Abuse Treatment (CSAT) and Center for Mental Health Services (CMHS) invited family members, youth in treatment or post-treatment for substance use or co-occurring mental health disorders, providers, researchers, and Federal and State-level policy-makers to participate in a consultative session designed to develop a recovery-oriented care model for adolescents and transition age youth¹ with substance use or co-occurring mental health disorders (SU/COD).

Recovery is a central component of SAMHSA's mission to ensure that individuals with substance use and/or mental health disorders have a life in the community. SAMHSA's mission includes promoting an array of recovery-oriented services and supports to build resilience and foster recovery in both its substance abuse and mental health prevention and treatment initiatives.

To date the concepts and principles of recovery-oriented care have been gaining acceptance for adults with substance use disorders and/or mental health disorders. Less attention, however, has been centered on understanding the need for a developmentally appropriate recovery system for adolescents and transition age youth with substance use or co-occurring mental health disorders.

For this reason, SAMHSA convened a small group of experts from across the United States who could bring different perspectives and expertise to the development of a youth-oriented recovery model of care. The goals of the two-day session were (1) to determine the essential elements of a recovery-oriented system of care for young people leading to the design and implementation of community-based, effective, and integrated models of care that would facilitate optimal youth development and wellness; and (2) to build bridges between the substance abuse and mental health fields, as well as other critical systems in the lives of youth and their families, to achieve improved integration of care. Prior to this meeting a number of previous SAMHSA-related activities set the stage for this work, including a 2005 CSAT summit which included adolescent focus groups on the concept of recovery and a 2005 three-phased process supported by CMHS examining how the concept of recovery as applied in the adult mental health field might be relevant to child and adolescent mental health services.

The timeliness of this 2008 meeting was reinforced by the recent passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as well as work on national health reform. SAMHSA is interested in ensuring that prevention, early intervention, treatment, and recovery from mental health and substance use disorders are an integral part of all reform efforts.

¹ Transition age youth represent young people moving to adulthood who have received services from the adolescent service system and may need continued services and supports from the adult system.

The consultative session planners employed a four-stage approach to identify the elements of a recovery-oriented system of care for adolescents and transition age youth with substance use or co-occurring mental health disorders. Steps included:

- Conducting a literature review and developing a briefing paper and resource materials that identified dimensions and elements of a recovery-oriented system;
- Developing a conceptual framework addressing the elements of a recovery-oriented system of care to structure and guide the deliberations of the participants of the consultative session;
- Convening a group of national experts representing a wide range of perspectives and facilitating a process to draw on their expertise to determine priority elements of a recovery-oriented system of care for youth and recommendations for future development and implementation; and,
- Comparing the results from the consultative session with findings from the literature review.

The conceptual framework included values and principles to serve as a foundation, the services and supports to be provided, the infrastructure necessary to assure an effective, efficient system that supports the concept of recovery, and outcomes to be achieved. The population focus for this model of care was adolescents and transition age youth who are or had been in treatment for substance use or co-occurring mental health disorders.

Organization of the Consultative Session Report

This report includes a discussion of the approach, conceptual framework, and working assumptions; background information on the prevalence of substance use and mental health disorders in adolescents and the evolution of the adolescent substance use and mental health service system; and current thinking on recovery-oriented systems of care. The results of the consultative session deliberations are included, specifying priority recommendations for the essential elements, challenges and opportunities for the development of recovery-oriented systems of care for youth, and recommendations for action at the Federal and State levels. The report also offers conclusions and next steps. The appendixes include (A) selected definitions of personal recovery, (B) definitions of recovery-oriented systems of care, (C) the recovery consultative session agenda, (D) the recovery consultative session participant list, (E) the recovery consultative session discussion questions, (F) elements of a recovery-oriented system of care identified by the literature and consultative session participants, (G) tables comparing elements by literature citations and consultative session group prioritization, (H) consultative session resource material tables, and (I) bibliography from the consultative session briefing document.

Context and Review of the Literature

The National Survey on Drug Use and Health (NSDUH) estimated that over 1.9 million (7.7 percent) adolescents aged 12 to 17 were dependent on or abused illicit drugs or alcohol in 2007. Over 4 percent (4.3 percent) of adolescents were classified with dependence on or abuse of illicit drugs in 2007, and 5.4 percent of adolescents were classified with dependence on or abuse of alcohol in 2007 (Office of Applied Studies [OAS], 2008).

Existing research reveals that many youth with substance use disorders also have co-occurring disorders. Across a range of studies, 54 to 95 percent of youth in alcohol and drug treatment have conduct or oppositional defiant disorder; mood disorders are evident in approximately half

of these teens; and 15 to 42 percent exhibit anxiety disorders (e.g., PTSD; social phobia) (Brown, n.d.). In Global Appraisal of Individual Need assessments (N=4,421) administered in CSAT-funded adolescent programs from 1998 through 2004, 74 percent of youth who met diagnostic criteria for substance use disorders also had at least one co-occurring condition. In fact, multiple co-occurring problems were the norm (Turner et al., 2004).

The 1999 Surgeon General's Report on Mental Health stated that almost 21 percent of children ages 9 to 17 were estimated to have mental health disorders with at least minimum functional impairment with 5 to 11 percent having extreme to significant impairment (United States Department of Health and Human Services [USDHHS], 1999). One study of mental health service use among youth reveals that nearly 43 percent of youth receiving mental health services in the United States have been diagnosed with a co-occurring disorder (CMHS, 2001). An analysis of data from the national evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program (Systems of Care) showed that among a sample of youth aged 11–18 with a diagnosis of serious emotional disturbance served between 2003 to 2008, 46.6 percent of the youth had at least one indicator of substance use or abuse.

Minkoff (2001) states that “co-morbidity is so common that dual diagnosis should be expected rather than considered an exception. Consequently, the application of best practices cannot be restricted to small subpopulations but rather must be extended to the development of models that apply to the entire system of care and that require integrated system planning involving both mental health and substance abuse treatment agencies” (p. 597).

For many years, research has demonstrated that for youth with SU/COD the acute care model of clinical intervention alone is not sufficient to enable youth to achieve treatment gains and sustain long-term recovery. First-year post-treatment relapse rates (at least one episode of substance use) for adolescents range from 60 to 70 percent (Brown et al., 1989; Godley et al., 2002; White, 2008). Treatment outcomes are worse for youth with co-occurring disorders, with poorer outcomes for adolescents with co-occurring externalizing disorders and those who move away from home (Brown and Ramo, 2006; White, 2008). The general consensus in the literature is that the risk of relapse is greatly increased when the adolescent with a substance use disorder also has a coexisting mental health disorder.

In recent years, delivery systems in both substance abuse and mental health have been undergoing major transformations. Systems and services in the addictions treatment field are undergoing a significant change, shifting from the “crisis-oriented, professionally directed, acute-care approach,” which focused on unique episodes, to a model that stresses continuing care, an ecological approach, and long-term recovery supports (White, 2008).

In child and adolescent mental health, groundbreaking work by Stroul and Friedman (1986) articulated the values and principles of a comprehensive system of care. Emphasizing a child-centered, youth-guided, family-focused approach, the system of care philosophy stresses a comprehensive array of effective community-based, culturally and linguistically competent services and supports that are individualized according to the needs of each child. Principles include developmentally appropriate services provided in the least restrictive setting, family and youth involved as full participants, and service system coordination and integration (Stroul and Friedman, 1986). A national evaluation of a cohort of 126 systems of care funded through SAMHSA's CMHS found that youth in systems of care, including those with co-occurring mental health and substance use disorders, achieved positive outcomes in a number of domains: youth grades improved, school attendance improved, youth involvement with juvenile justice

decreased, the level of overall emotional and behavioral problems declined significantly (including youth depression and anxiety), and suicide attempts declined (CMHS, 2008; CMHS, 2009).

Lessons learned from wraparound approaches within systems of care have relevance for a recovery-oriented model of care. Wraparound is a process for developing an individualized, strengths-based care plan involving the family and youth and utilizing both formal services and informal, natural supports to achieve positive outcomes in key domains of a young person's life. The positive youth development field also has much to contribute to the development of recovery-oriented systems of care.

Consultative Session Presentations

Presentations from key leaders at the meeting provided an important context for the consultative session discussion highlighting:

What the data tell us

- Data on youth entering substance use disorder treatment from the Global Appraisal of Individual Need (GAIN) assessments;
- The potential of a continuing care model for adolescents with SU/COD; and,
- Data from the Comprehensive Community Mental Health Services for Children and their Families national evaluation.

Youth perspectives

- Factors influencing youths' willingness to enter treatment;
- The importance of safe environments; and,
- The critical role of peers.

Family perspectives

- The importance of family voice;
- Expanded definition of families;
- The importance of a cultural lens in recovery-oriented systems of care; and,
- The importance of one-door to treatment.

Community perspectives

- A multi-agency collaboration in Tucson, Arizona serving youth with co-occurring substance use and mental health disorders; and,
- A community-based recovery-oriented system of care in Philadelphia, Pennsylvania.

System, service, and support issues

- Examples from an integrated substance abuse and mental health system in Cuyahoga County, Ohio; and,
- Lessons learned from a recovery-oriented system of care for adults in Detroit, Michigan.

Federal perspectives

- Principles of recovery and current recovery-focused efforts at CMHS; and,
- Needs assessment, design, and implementation of recovery models at CSAT.

Work and Recommendations of the Consultative Session

The work of the consultative session included drawing on the literature, extracting lessons learned from the presentations, and sharing participants' expertise in order to identify the design

elements of recovery-oriented systems of care for youth with substance use or co-occurring disorders. Throughout the course of the two-day meeting attendees were assigned to one of four discussion groups. Each group was asked to prioritize the top five elements for the following areas: values and principles, services and supports, infrastructure necessary for the development and operation of an effective system, and outcomes at the individual, family, and system levels. Prioritized elements are highlighted below. This listing is not comprehensive but provides a sense of what participants deemed most critical for a recovery-oriented system. Additional detail is provided in the appendixes of this report.

Values and Principles for a Recovery-Oriented System of Care

- Being family focused;
- Employing a broad definition of family;
- Being age appropriate;
- Reflecting the developmental stages of youth;
- Acknowledging the nonlinear nature of recovery;
- Promoting resilience;
- Being strengths-based; and,
- Identifying recovery capital.

Services and Supports

- Ensuring ongoing family involvement;
- Providing linkage;
- Assuring that the range of services and supports address multiple domains in a young person's life;
- Including services that foster social connectedness;
- Providing specialized recovery supports; and,
- Providing therapeutic/clinical interventions.

Infrastructure Elements

- Family involvement at the design and policy level;
- Policy changes at the Federal, State, and provider levels;
- Collaborative financing;
- Collaboration and integration across all youth-serving systems;
- Workforce development;
- Leadership; and,
- Accountability.

Outcomes

Youth

- Social connectedness;
- Reciprocity: increased capacity of the youth to give back to the community;
- Increased self-sufficiency;
- Increased number of developmentally appropriate assets;

System

- Support for family and sibling recovery; and,
- Easy access to service system with multiple entry points.

Challenges

Participants identified a number of challenges as well as opportunities for developing recovery-oriented systems of care noting that challenges and opportunities often correspond. What is a

challenge may also be viewed as an opportunity for change and action. Challenges included the following:

- Lack of shared language and common vision;
- Complexity of achieving change;
- Stigma;
- Disparities across race, ethnicity, culture, age, and gender;
- Lack of culturally and linguistically competent services and supports;
- Limited family and youth involvement;
- Lack of infrastructure supporting integrated systems of care and recovery;
- Financing;
- Service system coordination;
- Lack of appropriate outcome measures and accountability procedures;
- Inadequate workforce capacity;
- Lack of recovery-focused services and supports;
- Lack of care coordination;
- Confidentiality issues;
- Lack of statewide focus; and,
- A need for more research, evaluation, and dissemination.

Opportunities

Themes identified as opportunities included:

- A growing awareness of substance use and mental health issues and problems, including the high rate of co-occurring disorders in adolescents and transition age youth;
- An increase in pockets of excellence and promising practices of recovery-oriented services and supports in States and communities across the country;
- Opportunities for both public and private sector funding;
- Multiple formal and informal resources available in communities; and,
- Emerging technologies providing innovative approaches for outreach to care and support of young people in recovery.

Federal and State Recommendations

Consultative session participants developed a number of recommendations for Federal and State action to improve service delivery for young people with substance use and co-occurring mental health disorders. These recommendations called for:

- Improving integration across Federal departments and particularly across substance abuse and mental health centers;
- Developing a comprehensive financing strategy;
- Increasing collaboration among State agencies establishing interagency councils for planning and coordination;
- Aligning funding on Federal and State levels with recovery-oriented goals and providing appropriate incentives;
- Developing policies and funding that support key principles of a recovery-oriented system of care, especially family and youth involvement and cultural competence;
- Implementing Federal and State policies to facilitate the development, funding, and provision of recovery-oriented services and supports;

- Creating statutory vehicles to ensure sustainability;
- Undertaking strategies to increase public awareness about substance use, mental health, co-occurring disorders, and the concepts of resilience and recovery;
- Developing a research agenda on recovery-oriented systems of care; and,
- Supporting assistance to States and communities on policy and infrastructure development, best practices, and implementing research findings that support recovery-oriented care.

Conclusions

The participants of the consultative session, as intended, represented a range of perspectives including those of the substance abuse and mental health systems, families and young people, State and local administrators, providers, and researchers. Even given this diverse spectrum, the group demonstrated strong consensus and consistency on the values and principles of a recovery-oriented system of care, the services and supports essential to such a system, and the infrastructure necessary to support recovery-oriented systems of care nationwide. In particular, there was strong support for family involvement at every level from policy to direct service. The values and principles identified aligned with those articulated by Stroul and Friedman (1986) for a system of care for children and youth at risk of or with serious emotional disorders, providing a basis for common ground between the mental health and substance abuse fields. This beginning consensus provides an opportunity to further the development of recovery-oriented systems of care across both the substance abuse and mental health fields, particularly for young people with co-occurring problems.

The consensus on so many of the key elements of a recovery-oriented system of care for young people with substance use and co-occurring mental health disorders underscored the importance of creating holistic systems of care across all youth-serving agencies, including, but not limited to, substance abuse, mental health, Medicaid, child welfare, juvenile justice, and education. While the primary focus of the meeting was on the design of recovery-oriented systems of care and the essential elements of such systems, the need for integration became a critical theme. It became clear that ultimately service systems must be integrated to realize a well-functioning recovery-oriented system of care. Participants stressed the importance of integrating systems at the Federal, State, and community levels, as well as integrating individualized services and supports for each youth within those systems in order to attain comprehensive, coordinated, and holistic care. The system should be designed to meet the needs of the individual and family in a flexible, integrated, collaborative, and outcome-focused model. Implementing recovery-oriented systems of care will require a new mindset and transformation of systems and services focusing not on problems but rather on engendering hope, optimism, and the fulfillment of each young person's potential.

Next Steps

This Federal level endeavor represents a beginning collaboration across substance abuse and mental health focused on recovery as it applies to adolescents and transition age youth. Building on previous SAMHSA work the consultative session advanced an understanding of the essential elements of a recovery-oriented system of care for youth and what it will take to implement such systems in States and communities. The findings, however, only begin to lay the groundwork. Time was limited, the topics broad, and the process structured to identify highest priorities. Many critical issues such as youth involvement, disparities, cultural competence, and stigma were not adequately addressed. Still, the meeting provided a solid foundation for future work to be undertaken. It will be important for SAMHSA to continue this work to operationalize concepts of recovery for young people and to promote better integration of substance abuse and mental health service systems.

The focus of this project was limited to youth with identified substance use or co-occurring mental health disorders who have been or were in treatment. Future work should expand beyond this focus to include prevention and promotion of resilience in all youth and to address the challenges associated with youth, especially those at risk, who do not come in contact with the treatment system.

The following areas are highlighted as possible priorities for future work to build on the foundation established through this project:

- Engage a much broader cross section of young people in affirming and further defining the essential elements of a recovery-oriented system of care;
- Develop a definition of individual recovery for adolescents and transition age youth that is endorsed by both the substance use and mental health fields and that incorporates concepts of resilience and positive youth development;
- Explore in greater detail some of the concepts that participants identified as being critical to a recovery-oriented system of care including the nonlinear nature of recovery and recovery capital (i.e., how to build recovery capital for both the individual and the community);
- Examine more fully the concept of relapse as it relates to both adolescent substance abuse and mental health disorders;
- Further work to strengthen meaningful family and youth involvement in all levels of the system: at the practice, program, and policy levels;
- Address issues of disparities in the service system and examine how to ensure that recovery-oriented systems of care for youth are culturally and linguistically competent;
- Determine the most important and necessary core service components and supports that will enable young people to thrive in the community;
- Develop strategies for engaging important partners such as businesses to promote workforce opportunities and employment supports as a critical dimension of recovery for young people;
- Expand the focus to include prevention and early intervention strategies to promote resilience and recovery;
- Explore opportunities to implement some of the recommendations for Federal and State actions proposed by consultative session participants;
- Examine the steps to develop an integrated recovery-oriented system of care for young people with co-occurring substance use or mental health disorders; and,
- Assure that recovery support is an integral part of the implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and proposed health reform efforts.

Introduction

On November 13 and 14, 2008, invited family members, youth in treatment or post-treatment for substance use disorders, providers, researchers, and Federal and State level policy-makers participated in a consultative session, convened by the Substance Abuse and Mental Health Services Administration (SAMHSA) and its Center for Substance Abuse Treatment (CSAT) and Center for Mental Health Services (CMHS). The purpose of the consultative session was to develop a recovery-oriented care model for adolescents and transition age youth¹ with substance use or co-occurring mental health disorders (SU/COD).

Recovery is a central component of SAMHSA's mission to ensure that individuals with substance use and/or mental health disorders have a life in the community. SAMHSA's mission includes promoting an array of recovery-oriented services and supports to build resilience and foster recovery in both its substance abuse and mental health prevention and treatment initiatives. Most recently the importance of recovery services has been affirmed in SAMHSA's consensus principles (Hutchings and King, 2009) informing the national health-care reform debate.

“Recovery is frequently a more difficult, complex, and enduring process than our current treatment design would indicate” (White, 2008, pg. 130). Between 25 percent and 35 percent of all clients discharged from addiction treatment will be readmitted to treatment within 1 year, and nearly 50 percent will be readmitted within 2 to 5 years (Grella et al., 2003; Simpson et al., 2002; Simpson et al., 1999; White, 2008). First-year post-treatment relapse rates (at least one episode of substance use) for adolescents range from 60 to 70 percent (Brown et al., 1989; Godley et al., 2002; White, 2008). At least one-third of adolescents leaving treatment relapse in the first 30 days following discharge, and the proportion who relapse increases at each subsequent follow-up point (Brown and Ramo, 2006; White, 2008). To date the concepts and principles of recovery-oriented care have been gaining acceptance for adults with substance use disorders and/or mental health disorders. Less attention has been centered on understanding the need for a developmentally appropriate recovery system for adolescents and transition age youth with SU/COD.

The consultative session held on November 13 and 14, 2008, was designed to convene a small group of experts from across the United States who could bring different perspectives and expertise to the development of a youth-oriented recovery model of care. The goals of the two-day session were (1) to determine the essential elements of a recovery-oriented system of care for young people leading to the design and implementation of community-based, effective, and integrated models of care that facilitate optimal youth development and wellness; and (2) to build bridges between the substance abuse and mental health fields as well as other critical systems in the lives of youth and their families to achieve improved integration of care.

This report begins with discussion of the approach employed by consultative session planners. It proceeds to identify a conceptual model of the essential elements of a recovery-oriented system of care; working assumptions; background information; consultative session

¹ Transition age youth represent young people moving to adulthood who have received services from the adolescent service system and may need continued services and supports from the adult system.

presentation summaries; discussion group results; a summary of challenges, opportunities, and recommendations; conclusions; and next steps.

The appendixes in this report serve as a supplement to the information and include: (A) selected definitions of personal recovery, (B) definitions of a recovery-oriented system of care, (C) the recovery consultative session agenda, (D) the recovery consultative session participant list, (E) the recovery consultative session discussion questions, (F) elements of a recovery-oriented system of care identified by the literature and consultative session participants, (G) tables comparing elements by literature citations and consultative session group prioritization, (H) consultative session resource material tables, and (I) bibliography from the consultative session briefing document.

Approach

The consultative session planners employed a four-stage approach to identify the elements of a recovery-oriented system of care for adolescents and transition age youth with substance use or co-occurring mental health disorders. Steps included:

- Conducting a literature review and developing a briefing paper and resource materials that identified the dimensions and elements of a recovery-oriented system;
- Developing a conceptual framework addressing the elements of a recovery-oriented system of care to structure and guide the deliberations of the participants of the consultative session;
- Convening a group of national experts representing a wide range of perspectives and facilitating a process to draw on their expertise to determine priority elements of a recovery-oriented system of care for youth and recommendations for future development and implementation; and,
- Comparing the results from the consultative session with findings from the literature review.

Literature Review and Briefing Document

Prior to the consultative session planners conducted a review of selected literature on recovery-oriented systems for youth and adults with substance use and/or mental health disorders. Planners employed a snowball nomination approach, using interviews with national experts to identify seminal documents in the published literature as well as Federal government papers and reports. The planners employed qualitative research methods to identify, code, and categorize the recovery system elements in the material. These elements were then weighted according to the number of times the element was mentioned in the selected literature. The findings from this review informed the development of a briefing document sent to all consultative session participants prior to the meeting. The briefing materials catalogued and arrayed the key elements of a recovery-oriented system of care in six areas: values, principles, outcomes, formal and informal services and supports, and infrastructure. The purpose of these materials was to present selected work in the fields of adult substance abuse and mental health, child/adolescent mental health, and adolescent substance abuse to inform the consultative session participants and provide a catalyst for discussion at the meeting. The material, which was included in the meeting briefing document and is referenced in this report, did not represent the universe of research on recovery; rather, the intent was to synthesize relevant information from key sources to provide a context and to help facilitate the discussion process at the consultative session.

Selected SAMHSA Activities

A number of previous SAMHSA-related activities have set the stage for this work. In 2005, CSAT hosted a recovery summit, which expanded the recovery concept to adolescents with substance use disorders. The results of focus groups with adolescents and discussions at that national meeting have provided the impetus for the development of a youth focused recovery-oriented model of care.

Concurrently, a three-phase process supported by CMHS's Child, Adolescent and Family Branch in 2004–2005 examined how the concept of recovery as developed in the adult mental health field might be relevant to child/adolescent mental health services. Four recommendations resulting from this process addressed the importance of hope, optimism, and future-oriented planning; the need to develop and test interventions related to hope and positive emotions; the

importance of acknowledging and addressing trauma, both individual experience with negative events such as abuse as well as trauma related to seeking and receiving treatment; and, the importance of applying resilience concepts to mental health practice. Participants in this process recommended that the term “resilience and recovery” be used, rather than “recovery” alone.

CSAT/CMHS/SAMHSA wanted to build on this work and move forward to articulate the key values and principles of a recovery-oriented system for youth; to identify the key services, supports, and infrastructure needed to operationalize a recovery-oriented system; and to identify desired outcomes for youth.

Conceptualizing the Essential Elements of a Recovery-Oriented System of Care

Figure 1: Conceptual Diagram

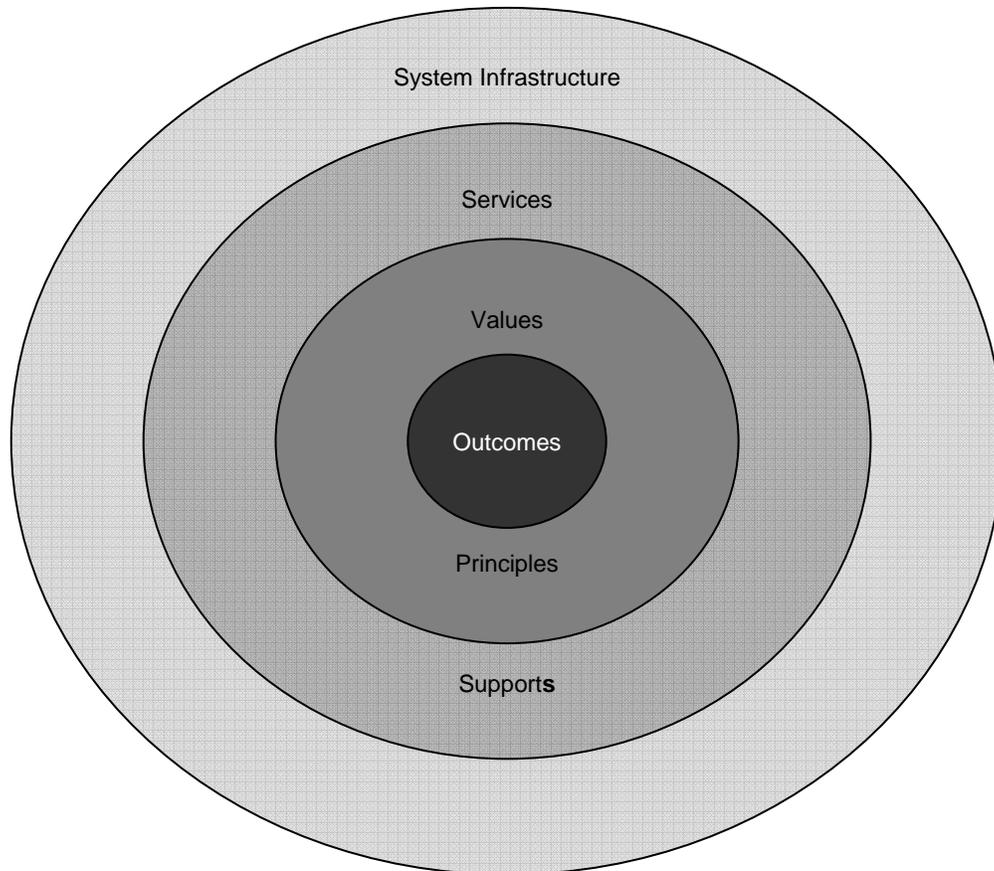


Figure 1 provides a visual depiction of a conceptual framework for a recovery-oriented system of care designed to assist the work of the consultative session. Each of the concentric circles represents the key elements of that framework with the outcomes for youth and families and the values and principles of the system at the core. The focus of the consultative session was to identify in more detail the critical aspects of each of these elements in order to design an effective recovery-oriented system for youth with substance use or co-occurring mental health disorders.

Consultative Session

The two-day consultative session proceeded in accordance with a specific agenda. To prepare participants for the deliberative discussions speakers presented information in three substantive areas: findings from research, youth and family perspectives, and community and provider perspectives on recovery. Over the 2 days attendees participated in two break-out sessions to identify and prioritize:

- Key values and principles in recovery-oriented care;
- Elements and components of a recovery-oriented system including services, supports, and infrastructure; and,
- Positive outcomes for youth.

The discussion groups were facilitated by experts familiar with the issues under discussion. Each group reported back at plenary sessions.

Working Assumptions

Consultative session planners and SAMHSA staff identified several working assumptions for the consultative session and this report. These assumptions included the following:

- There are many definitions and visions of personal recovery.² The purpose of the consultative session was not to come to a consensus on a definition of recovery at the individual level; rather it was to identify key concepts and elements of recovery for youth, families, and communities based on different perspectives and to determine how these concepts may be operationalized in a recovery-oriented system of care.
- The literature is clear that recovery is a multidimensional process and that there are many paths to recovery. The adult substance abuse literature supports individual recovery that may or may not involve participation in treatment. This paper acknowledges the nontreatment path to recovery; however, the work of the consultative session was to conceptualize a recovery system for youth who are or have been involved in substance use or co-occurring mental health disorder treatment.
- CSAT supports the goal of abstinence for all youth who enter substance abuse treatment; however, CSAT is aware that achieving abstinence is a process that is not necessarily linked with treatment completion for youth. Most youth will use substances again after treatment and the majority of youth alternate between periods of abstinence and some substance use. It is also often the case that more than one treatment episode will be required before youth achieve abstinence. CSAT strives for the goal of abstinence, knowing that in the process treatment can have an impact on the reduction of use and can increase the health and well-being of youth and their families.
- Youth with co-occurring substance abuse and mental health disorders make up an important subset of youth who will profit from a recovery-oriented system. It is assumed that the complex nature of the challenges these youth face require specialized responses to their needs (Gagne et al., 2007).

² Definitions of personal recovery are included in Appendix A of this document.

Background

The National Survey on Drug Use and Health (NSDUH) estimated that over 1.9 million (7.7 percent) adolescents aged 12 to 17 were dependent on or abused illicit drugs or alcohol in 2007. Over 4 percent (4.3 percent) of adolescents were classified with dependence on or abuse of illicit drugs in 2007 and 5.4 percent of adolescents were classified with dependence on or abuse of alcohol in 2007 (Office of Applied Studies [OAS], 2008).

Marijuana/hashish was the illicit drug with the highest rate of dependence or abuse among adolescents aged 12 to 17, with the NSDUH estimating that 783,000 adolescents (3.1 percent) met this criteria in 2007 (OAS, 2008). The NSDUH estimated the percentage of adolescents aged 12 to 17 with past year dependence on or abuse of specific illicit substances in 2007 as: nonmedical use of psychotherapeutics (1.3 percent), pain relievers (0.9 percent), hallucinogens (0.5 percent), cocaine (0.4 percent), inhalants (0.4 percent), stimulants (0.3 percent), tranquilizers (0.2 percent), sedatives (0.1 percent), and heroin (0.0 percent) (OAS, 2008).

Many youth with substance abuse disorders also have co-occurring disorders. Across a range of studies 54 to 95 percent of youth in alcohol and drug treatment also have conduct or oppositional defiant disorder; mood disorders are evident in approximately half of these teens and 15 to 42 percent exhibit anxiety disorders (e.g., post-traumatic stress disorder; social phobia) (Brown, n.d.). In Global Appraisal of Individual Need assessments (N=4,421) administered in CSAT-funded adolescent programs from 1998 through 2004, 74 percent of youth who met diagnostic criteria for substance use disorders also had at least one co-occurring mental health condition. In fact, multiple co-occurring problems were the norm (Turner et al., 2004).

The 1999 Surgeon General's Report on Mental Health stated that almost 21 percent of children ages 9 to 17 were estimated to have mental health disorders, with at least minimum functional impairment with 5 to 11 percent having extreme to significant impairment (United States Department of Health and Human Services [USDHHS], 1999). One study of mental health service use among youth reveals that nearly 43 percent of youth receiving mental health services in the United States have been diagnosed with a co-occurring substance use disorder (CMHS, 2001).

Minkoff (2001) states that "co-morbidity is so common that dual diagnosis should be expected rather than considered an exception. Consequently, the application of best practices cannot be restricted to small subpopulations but rather must be extended to the development of models that apply to the entire system of care and that require integrated system planning involving both mental health and substance abuse treatment agencies" (p. 597).

Treatment outcomes are worse for youth with co-occurring disorders, with poorer outcomes for adolescents with co-occurring externalizing disorders and those who move away from home (Brown and Ramo, 2006; White, 2008). The general consensus in the literature is that the risk of relapse is greatly increased when the adolescent with a substance use disorder also has a coexisting mental health disorder. Several studies have shown the prognostic significance of co-occurring conduct disorder and related externalizing disorders (e.g., oppositional defiant disorder and attention deficit/hyperactivity disorder) for substance abusing youth (Brown et al., 1996; Crowley et al., 1998; Myers et al., 1995; Winters et al., 2008).

For adolescents with externalizing disorders, their problems of poor affiliation with parents, schools, and prosocial institutions may be contributing to poorer treatment outcomes (Winters et al., 2009). One study (Rowe et al., 2004) found that adolescents with both internalizing and externalizing disorders returned to intake levels of drug use at 1 year post-treatment, whereas adolescents without co-morbid disorders showed significantly reduced levels of use at 6 and 12 months post-treatment (Winters et al., 2008; Winters et al., 2009).

For many years, research has demonstrated that for youth with substance use or co-occurring mental health disorders the acute care model of clinical intervention alone is not sufficient to enable youth to achieve treatment gains and sustain long-term recovery.

Continuing care has been widely recommended as a critical component for maintaining treatment gains after residential treatment for both adults and adolescents with substance use disorders (Belenko and Logan, 2003; Brown et al., 1994; Catalano et al., 1989; Dasinger et al., 2004; Donovan, 1998; Godley et al., 2006, Jainchill et al., 2000; Kaminer, 2001; McKay, 1999); however, there is little research on comprehensive recovery-oriented models for adolescents.³

“There is general agreement among adolescents who have resolved alcohol or other drug problems and those who have assisted in that process that recovery is more than the removal or radical deceleration of alcohol and drug use from an otherwise unchanged life. Adolescent alcohol and other drug problems are often closely bundled with other personal or family problems. Recovery connotes the broader resolution of these problems and the movement toward greater physical, emotional, and relational health. Recovery also frequently involves improved educational and vocational performance, the formulation of and movement toward life goals, and acts of service to the community” (White and Godley, 2007, p. 1).

“Delivery of care systems and services in the addictions treatment field are undergoing a significant transformation, key people in the behavioral health field are re-examining how they view people with substance abuse problems. This development constitutes a sea change from the ‘crisis-oriented, professionally directed, acute-care approach,’ which focused on unique episodes to a model that stresses, ‘long-term recovery supports’ and acknowledges the need for wide-ranging conduits in healing” (White, 2008, p. v). Figure 2 illustrates an ecological model depicting components of a recovery-oriented system.

³ For specific definitions of individual recovery, see Appendix A and for specific definitions related to a recovery-oriented system of care, see Appendix B.

and/or treatment and support, at the right level, for the right period of time by the right practitioner, agency or sponsor every time” (Flaherty, 2006, p.7).

The recovery management model of addiction treatment pioneered for adults shifts the focus of care from professional-centered episodes of acute symptom stabilization toward client-directed management of long-term recovery. It wraps traditional treatment within a more sustained continuum of prerecovery support services to enhance recovery readiness. In addition to in-treatment recovery, support services enhance the strength and stability of recovery initiation, and post-treatment recovery support services enhance the durability and quality of recovery maintenance (White, Kurtz, and Sanders, 2006).

Adult models emphasize client strengths and resiliency, client empowerment, destigmatizing or “normalizing” a person’s experiences with behavioral health disorders, an appreciation of the ecology of recovery, including the importance of the family and community, and the need for ongoing monitoring, feedback, and encouragement (Boyle, et al., n.d.).

Mental health research on recovery for adults with serious mental illness has identified basic components of recovery for this population, which include being supported by others, renewing hope and commitment, engaging in meaningful activities, accepting the limitations of the illness, overcoming stigma, assuming control, managing symptoms, and becoming empowered (Davidson et al., 2007). Adults with mental illness identified their most significant need and the most significant facilitator of their recovery as “...having someone I can trust who will stick with me over time, through good times and bad, to support me in my recovery” (Davidson et al., 2007, p. 28). Immediate access to those services that people may require at any given time and access to natural and community supports outside the formal health-care system are also essential. “Recovery support cannot be an ‘add-on’ to existing services, supports or systems. Promoting recovery needs to be the overarching aim of all services and supports” (Davidson et al., 2007, p. 31).

There has been relatively little conceptual work or research specifically addressing the concept of recovery for youth with mental health problems and their families. Groundbreaking work by Stroul and Friedman (1986) articulated the values and principles of a comprehensive system of care. Emphasizing a child-centered, youth-guided, family-focused approach, the system of care philosophy stresses a comprehensive array of effective community-based, culturally and linguistically competent services and supports that are individualized according to the needs of each child. Principles include developmentally appropriate services provided in the least restrictive setting, family and youth involved as full participants, and service system coordination and integration (Stroul and Friedman, 1986). A system of care can help children, youth, and their families function better at home, in school, in communities, and throughout life (CMHS, 2008; CMHS, 2009).

To date many States and communities have implemented systems of care to serve the needs of children and adolescents with serious emotional disorders. Studies have shown that a significant number of these young people have co-occurring substance use issues.⁵ A national evaluation of a cohort of 126 systems of care funded through SAMHSA’s CMHS found that youth in systems of care achieved positive outcomes in a number of domains: youth grades

⁵ Using data from the Comprehensive Community Mental Health Services for Children and Their Families national evaluation, Dr. Christine Walrath found co-occurring substance use disorders among 46.6 percent of children and adolescents with serious emotional disturbances (see page 15).

improved, school attendance improved, youth involvement with juvenile justice decreased, the level of overall emotional and behavioral problems declined, including youth depression and anxiety, and suicide attempts declined (CMHS, 2008; CMHS, 2009). Among youth with secondary diagnoses of substance use disorders, functional impairment at intake was significantly worse than for youth without substance use disorders. Youth with substance use disorders showed significantly greater rates of improvement over the first year of services within systems of care (CMHS, 1999).

Operationalizing system of care values, the concept of *wraparound* was developed for youth with mental health disorders to individualize services and supports within a system of care. Wraparound is defined "...as a team-based planning process intended to provide individualized, coordinated, family-driven care to meet the complex needs of children who are involved with several child- and family-serving systems (e.g. mental health, child welfare, juvenile justice, special education), who are at risk of placement in institutional settings, and who experience emotional, behavioral, or mental health difficulties. The wraparound process requires that families, providers, and key members of the family's social support network collaborate to develop a creative plan that responds to the particular needs of the child and family and builds on their strengths. The care plan includes an array of formal and 'natural' services and supports that address multiple life domains: family, home, emotional and psychological, social and recreational, education, vocational, safety and crisis, cultural and spiritual, medical, and legal. Team members then implement the plan and continue to meet regularly to monitor progress and make adjustments to the plan as necessary. The team continues its work until members reach a consensus that a formal wraparound process is no longer needed" (Bruns et al., 2004, p.1).

Building on these developments in child and adolescent mental health and the recommendations of the President's New Freedom Commission, in 2005 an effort was undertaken to look at the concept of recovery as it relates to children with mental health disorders and their families. Feedback from youth, families, service providers, and children's mental health administrators culminated in a report (Friesen, 2005) and an article (Friesen, 2007). Informants in this process identified a number of recovery elements (a holistic view of people with mental health challenges, strengths-based, individualized, and promoting empowerment and self-direction) that they felt were consistent with system of care principles (Stroul and Friedman, 1986) and resilience concepts widely embraced within the children's mental health field. Recovery concepts that were seen as "value added" (i.e., not explicitly contained within system of care principles), included healing historical trauma, respect, life planning, stigma reduction, and an emphasis on hope and optimism.

Emphasizing resilience and the unique developmental aspects of a recovery process for youth is essential. Thus the elements of positive youth development, a process which prepares young people to meet the challenges of adolescence and adulthood through a coordinated, progressive series of activities and experiences which help them to become socially, morally, emotionally, physically, and cognitively competent (National Collaboration for Youth Members, 1998) must be incorporated into the conceptual model of recovery for youth.

Amodeo and Collins (2007) state that the positive youth development philosophy emphasizes an asset-based and competence-building approach in which youth take active, collaborative roles in developing long-range plans for their futures. The positive youth development approach encourages community-based activities that promote prosocial development and are available to everyone. This philosophy fosters holistic growth for a youth, which promotes an increased

understanding of the youth's cultural memberships and allows the youth to understand the importance of both social relationships and relationships with the community.

The cumulative effect of the learning across the substance use and mental health fields has resulted in nothing less than a new vision and a new appreciation of what is necessary to enable young people with substance use or co-occurring mental health problems to lead fully functioning, meaningful lives in the community. The work of the consultative session was to begin applying the lessons learned to envisioning and implementing recovery-oriented systems of care for youth with substance use or co-occurring disorders.

Consultative Session Presentation Summaries

Day 1: Opening Remarks

Sybil Goldman, M.S.W., Senior Advisor

Georgetown University Center for Child and Human Development, Washington, DC

Sybil Goldman welcomed the participants to the consultative session and stated that the purpose of the session was to design a recovery-oriented system of care for adolescents and transition age youth with substance use disorders or co-occurring mental health disorders. SAMHSA invited youth, family members, providers, researchers, and State and local government officials to inform the development of this model. Ms. Goldman believed that an effective system should give these youth the hope they deserve, as well as the services and supports they need to achieve recovery.

Ms. Goldman stated that to date, research has not focused on the concepts and principles of recovery for adolescents with substance use and co-occurring mental health disorders. Therefore, fewer data exist to inform the development of a recovery-oriented system of care for these youth.

Ms. Goldman addressed the second goal of the consultative session: bridging child-serving systems and eliminating silos. She asserted that recovery should be a comprehensive, holistic process, with no wrong door through which youth can enter the system. Creating a collaborative system needs to be informed by data as well as the collective perspectives of youth, families, and providers. Ms. Goldman recognized that the participants represent diverse backgrounds and that each would contribute uniquely to the development of a framework to better understand adolescent and transition age youth substance use or co-occurring mental health disorder treatment and recovery.

Larke Huang, Ph.D., Senior Advisor on Children

Substance Abuse and Mental Health Service Administration (SAMHSA), Rockville, MD

Dr. Huang emphasized the importance of addressing recovery for youth and restated that SAMHSA considers recovery a critical component of its mission. She acknowledged the adult focus of most recovery research to date and stressed the need for more input on framing recovery for youth.

Dr. Huang suggested that attendees were participating in a triangulation approach utilizing adolescent substance abuse and mental health treatment data; asking providers, youth, and families for their opinions about what works; and having national experts synthesize the information to create a recovery-oriented system of care framework for youth with substance use or co-occurring mental health disorders.

Dr. Huang thanked the participants for their time and eagerness to share their expertise and voiced her hope that this meeting would result in exciting information that would move the field forward.

Randy Muck, M.Ed., Chief, Targeted Populations Branch
Center for Substance Abuse Treatment, SAMHSA, Rockville, MD

Mr. Muck thanked participants for attending the recovery consultative session and stated that CSAT would use the results of the session to inform the development of a grant program to operationalize recovery-oriented systems of care for youth.

Mr. Muck then outlined the working assumptions guiding the consultative session. He emphasized that the purpose of the session was to determine essential elements of recovery for youth, families, and communities. Mr. Muck recognized the nontreatment path to recovery, but reminded participants that the focus of the consultative session was on youth who are or have been in substance use or co-occurring mental health disorder treatment. Mr. Muck noted that CSAT supports the goal of abstinence for all youth who enter substance abuse treatment, but acknowledged that achieving abstinence is not necessarily linked with substance abuse treatment completion for youth. Mr. Muck concluded by stating that youth with substance use and co-occurring mental health disorders are an important group who stand to benefit from recovery-oriented systems.

Mr. Muck asked participants to prioritize a set of values, principles, services, supports, infrastructure, and outcomes necessary for a comprehensive recovery-oriented system of care for youth. Mr. Muck thanked participants for their time and looked forward to reviewing the consultative session's report.

Panel 1: What Does the Research Tell Us?

Research To Inform Planning and Development of Recovery Services for Youth, Families, and Communities

Mark Godley, Ph.D., Director of Research and Development
Chestnut Health Systems, Normal, Illinois

Dr. Godley presented an overview of youth entering substance use disorder treatment and described the potential of a continuing care model.

According to the 2002 National Survey on Drug Use and Health (NSDUH) the onset of substance use disorders typically begins during adolescence or early adulthood. Among substance-dependent adults, 90 percent report beginning to use substances before the age of 18, and approximately 50 percent began using substances before the age of 15. Epidemiological studies suggest that approximately 58 percent of people in sustained recovery indicate that substance use disorders start early, last for years, and improve over time. Dr. Godley reported that most adolescents in need of substance abuse treatment do not receive it, however. The 2005 NSDUH classified almost 9 percent of adolescents (8.9 percent) as abusing or dependent on alcohol or drugs, and reported that 0.5 percent of adolescents received substance abuse treatment.

Dr. Godley described the characteristics of 15,254 youth (12–17 years) in the 2007 CSAT national dataset. Of these adolescents, 73 percent were male, 42 percent were white, 28 percent were Hispanic, 16 percent were African-American and 79 percent were between 15–17 years of age. The majority of adolescents were treated in outpatient (71 percent) or intensive outpatient (9 percent) settings. Among adolescents in a residential setting (20 percent), most (17 percent) were in long-term (over 30 days) residential treatment.

Most adolescents (83 percent) presented at substance abuse treatment meeting the criteria for a substance abuse diagnosis within the past 12 months, and half of the sample also met criteria for substance dependence within the past year. Almost every adolescent in the sample (94 percent) could provide at least one reason to stop using alcohol and other drugs; 29 percent of adolescents acknowledged having an alcohol and other drug problem, while only 26 percent believed that they needed any treatment. Dr. Godley stated that these data emphasized the need for motivational interviewing and other treatment techniques designed to engage and retain adolescents in substance abuse treatment.

Many adolescents with substance use disorders also have co-occurring mental health disorders. Sixty-six percent of adolescents in the sample presented at substance abuse treatment with a co-occurring psychiatric disorder. Externalizing disorders such as conduct disorder (50 percent) and attention deficit/hyperactivity disorder (42 percent) were more common than internalizing disorders such as major depressive disorder (35 percent), traumatic stress disorder (24 percent), or general anxiety disorder (14 percent). Almost two-thirds (63 percent) of the sample had been victimized physically, sexually, or emotionally, with 45 percent reporting high-severity victimization defined as victimization occurring multiple times, by multiple people, involving someone they trusted, involving sexual penetration, and not being believed by people when he or she sought help.

The National Institute on Drug Abuse (NIDA) recommends substance abuse treatment last at least 90 days; however, fewer than 25 percent of adolescents remain in treatment for this period. Fewer than half of adolescents (47 percent) have planned discharges from substance abuse treatment, which means that over half of adolescents in substance abuse treatment have not successfully completed treatment. Using data from one State in 2000, Dr. Godley found that 64 percent of adolescents did not receive any continuing care within 90 days of discharge from substance abuse treatment.

Dr. Godley defined aftercare and continuing care. Aftercare aims to maintain the clinical gains made in substance abuse treatment using a step-down model. The aftercare model assumes that an individual completes each stage of treatment (assessment, residential treatment, intensive outpatient, outpatient) and successfully links to the next level of care. Dr. Godley acknowledged that the aftercare model works for a small percentage of individuals, but relatively few youth receive this model. A continuing care model includes the provision of a treatment plan and organizational structure that will ensure that a person receives whatever kind of care he or she needs at the time. The treatment program thus is flexible and tailored to the shifting needs of the individual.

Dr. Godley suggested using a continuing care model. In an analysis of adolescents discharged from residential treatment followed by continuing care, approximately 80 percent of adolescents successfully linked to continuing care services when services were offered within the same agency. Forty percent of adolescents were successfully linked to continuing care when they were referred to another agency, and about ten percent of adolescents with an unplanned discharge accessed continuing care services. Dr. Godley observed that the most likely time for an adolescent to link to continuing care services comes within the first 1 to 2 weeks following discharge from residential care. Adolescents with an unplanned discharge had little chance of accessing continuing care services.

Dr. Godley concluded his presentation by observing that substance abuse treatment helps adolescents, but many adolescents are not engaged or retained in treatment. Continuing care can prevent or minimize relapse, but most adolescents do not have access to these services. A

need exists for a greater diversity of substance abuse treatment services. Dr. Godley recommended that systems serving adolescents provide recovery supports and services as soon as possible, develop activities free of alcohol and other drugs, increase training and support to parents and other caregivers to support recovery and minimize relapse, decrease in-home drug use and fighting, and increase contact with peers who do not use alcohol and drugs in school and treatment.

Children With Co-Occurring Problems: What Are Their Characteristics, Experiences, and Outcomes?

Christine Walrath, Ph.D., Vice President
Macro International, Inc., New York, New York

Dr. Walrath presented a snapshot of youth with substance use/abuse problems from the Comprehensive Community Mental Health Services for Children and Their Families national evaluation data. Better known as the System of Care (SOC), the initiative is the largest children's mental health services project funded by the Federal government with \$1.38 billion spent to date and \$108 million appropriated for FY 2009. The purpose of the initiative is to encourage the development of home- and community-based systems of care in States, political subdivisions of States, American Indian tribes or tribal organizations, and territories that meet the needs of children and adolescents with serious emotional disturbances and their families. The system of care philosophy states that the mental health needs of children, adolescents, and their families can best be met by providing intensive and comprehensive services and supports within their home, school, and community environments.

The national evaluation of the SOC gathers data from children and families across life domains. Dr. Walrath stated that the national evaluation was not designed as an evaluation of substance use/abuse and as such it does not include a full compendium of in-depth comprehensive substance use or abuse measures and indicators. With these caveats Dr. Walrath stated that the national evaluation data could identify prevalence rates of substance use/abuse problems among children entering SOC, substance use/abuse histories, demographic and psychosocial characteristics, service experiences, and outcomes of children served in SOC. Dr. Walrath constructed several variables to measure substance use/abuse in the SOC evaluation data for youth aged 11–18, including presenting problem, self-reported specific substance use in the last 30 days, caregiver reported substance use in the last 6 months, and diagnosis. Dr. Walrath used data on 2,751 youth served in SOC from Phases IV and V (2003 to 2008). She found that among the 2,751 youth aged 11–18 entering the system of care between 2003 and 2008, 46.6 percent (1,282) of youth had at least one indicator of substance use/abuse.

Examining demographic, psychosocial, and referral characteristics of this subset, 56.2 percent were male, the median age was 14.9 years old, 36 percent were white, 28.7 percent were black, 21.7 percent were Hispanic, and 53.6 percent lived below the poverty level. Mental health (28.9 percent) and justice (court, family court, probation and corrections) (26.7 percent) were the largest referral sources. Approximately half of the youth had a history of being a runaway (46.4 percent) and being exposed to domestic violence (48.9 percent). With regard to lifetime family risk, 42.3 percent report mental illness and 69.3 percent report substance use problems. The clinical and functional indicators at entry into SOC reveal very high percentages of youth in the clinical range of the Child Behavior Checklist externalizing (83.1 percent) and internalizing (61.4 percent) scales. Over 62 percent (62.7 percent) of youth had been suspended or expelled, and 56.8 percent reported law enforcement involvement in the past 6 months. Among the 1,282 youth with a substance use/abuse indicator, 51.6 percent presented with a substance

use/abuse problem; 64.7 percent of youth reported use in the last 30 days; 51.6 percent had a caregiver report of use in the last 6 months; and 22.2 percent had a clinical diagnosis of a substance use disorder as measured by the *Diagnosis and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV). Among youth who used at least one substance, the average number of substances used in 30 days prior to intake was 1.6 and ranged from 1 to 9 substances. This was driven primarily by marijuana (62.2 percent) and alcohol (50.2 percent) use. These data reveal that a high percentage of youth enter mental health systems of care with substance use/abuse problems.

Six-month follow-up data on service experience and clinical/functional indicators were available for a subset of youth (n = 686). Among those youth, over 71 percent (71.3) received individual therapy, 56.7 percent received assessments, 38.3 percent received medication monitoring, and 36.6 percent received family therapy during their first 6 months of care. Additionally, 11.7 percent of youth received care at a residential treatment center and 10.3 percent entered the hospital for inpatient treatment. A variety of support services were provided to these youth, including case management (64.5 percent), informal supports (33.5 percent), transportation (27.8 percent), and caregiver or family support (27.6 percent). Statistically significant improvement across clinical and functional indicators was found at 6-month follow-up, including significant improvement in externalizing and internalizing behavior problems, suspension and expulsion, contact with law enforcement, drug and alcohol use and living stability.

Dr. Walrath reminded participants that these are youth with serious emotional disturbances at risk for out-of-home placement and not the larger population of youth with substance use/abuse or co-occurring mental health problems. These youth have experienced high levels of substance use and exhibit clinical and functional problems at entry into service.

Dr. Walrath identified questions that the consultative session participants needed to address including: How should we frame treatment success? What measures should be used to identify improvement? How do statistical decreases translate into reality? Are the incremental decreases in substance use sufficient? Is it realistic to expect abstinence as a treatment outcome? Should we develop other indicators such as substance use severity to better highlight improvements?

Panel 2: Youth and Family Perspectives

Recovery as a Part of Treatment: A Young Person's Perspective

Elise Lopez, Program Assistant

Compass Behavioral Health Care, Tucson, Arizona

Ms. Lopez shared a young person's perspective of substance abuse treatment and recovery. Ms. Lopez works with the Clean and Sober Theater, which provides peer-to-peer drug education and awareness to youth.

Ms. Lopez stated that many youth enter substance abuse treatment with a preconceived notion about whether treatment will work. Courts often compel many youth to enter substance abuse treatment, thus a youth's first impression of treatment matters. Ms. Lopez believes that youth begin using alcohol and other drugs for a variety of reasons. Some youth seek the "rush" that substances provide while others prefer substances that allow the youth to relax. According to Ms. Lopez, issues that can affect a youth's willingness to enter treatment include:

- Whether youth are presented with a welcoming environment;

- Whether substance abuse treatment clinicians use jargon or interact with youth at their level; and,
- Whether substance abuse treatment clinicians judge youth.

Ms. Lopez believes a safe environment must first be established for the youth and that providers should develop an individualized treatment plan that addresses the reasons why the youth began using alcohol and other drugs. Substance abuse treatment providers must establish a consistent set of guidelines and values governing a youth's behavior.

Ms. Lopez asserted that after a youth leaves substance abuse treatment, several environmental factors may affect the youth's ability to remain sober. A youth spends a significant portion of his/her day in school; however, schools do not always address substance use in the student body. School administrators and staff may not be trained to identify substance use. Some school administrators refuse to acknowledge that substance use exists in their schools while others do not know how to support youth in recovery.

Peers influence a youth's behavior and can frequently encourage and enable substance use. While a youth is in substance abuse treatment, clinicians should determine whether a youth's current peer network would support the youth's recovery. If not, substance abuse treatment clinicians should encourage the youth to develop new friendships. Upon leaving treatment, opportunities in the community should exist to support the youth's recovery. Certain adult substance use recovery models may not appeal to youth, so communities should develop other youth-friendly sober opportunities and activities.

A youth's family may also affect the youth's recovery. While many families provide supportive environments, families do not always receive the training necessary to handle relapse or engage in relapse prevention. Many youth believe that their families will be angry if they relapse. The youth will therefore attempt to conceal the relapse instead of acknowledging it and seeking support. Substance use/abuse may also exist in a youth's family members and steps must be taken to address these substance use issues. Ms. Lopez noted that this often requires the family to acknowledge that they are part of the problem, which can be challenging. If families do not deal with familial substance use issues, the chances of a youth relapsing could increase.

Ms. Lopez concluded her presentation by offering three strategies to support youth in recovery:

- Encourage youth to pursue their passions. Engaging in an activity important to the youth can allow him/her to develop positive behaviors and hopefully avoid the negative factors that caused the youth to begin using alcohol and other drugs;
- Provide peer support and positive role models. Youth can support each other through recovery and adult role models can provide examples of how to live; and,
- Eliminate tokenism. The youth's perspective should be valued and encouraged. When a youth believes that an adult listens to him/her, it increases the youth's self-esteem and supports his/her recovery.

Family Member Perspective

Shannon CrossBear, Training and Technical Assistance Specialist

National Federation of Families for Children's Mental Health, Hovland, Minnesota

Ms. CrossBear spoke about the value of family voice from the perspective of a family member. Ms. CrossBear began by addressing two questions: why family voice is important and whether

family voice is valued as a fundamental component of the process and not just an add-on. She believed that a paradigm shift occurred a few years ago following the CSAT sponsored Joint Meeting on Adolescent Treatment Effectiveness (JMATE) when the substance abuse field began to move away from the “them versus us” mentality to a greater emphasis on the value of family voice. Family voice is unequivocally important for a few key reasons. Family voice provides examples based on experience and ground level information and connection, and adds to the growing base of evidence. Imposed outcomes may not be the right outcomes to work toward from family and youth perspectives. Ms. CrossBear defined family-driven systems as those in which families have a primary decision-making role in the care of their own children as well as the policies and procedures governing all children in their community, State, tribe, territory, and Nation. This includes choosing supports, services, and providers; setting goals; designing and implementing programs; monitoring outcomes; and determining the effectiveness of all efforts to promote the recovery, resilience, and well-being of children and youth. Ms. CrossBear charged the consultative session participants to ask themselves what it means to design a family-driven system and what services and supports are needed by families struggling every single day.

Ms. CrossBear advocated for an expansive definition of families to include biological, adoptive, or foster parents and their partners, grandparents, siblings, other kinship caregivers, friends, and others as defined by the family. Youth should be viewed in conjunction with their families. In a family-driven system it is essential to promote full participation of families and youth in the development of a recovery-oriented care model, to work to plan services and supports, and to have the families and youth whose lives will be impacted lead the charge. With a mental health door to services and a separate substance abuse door to services, Ms. CrossBear asked, “Where do families and youth get connected and have their voices heard?” Although mechanisms for family voice have been organized in mental health, she noted that an organization representing families and youth with substance use disorders does not exist. There is no mechanism in place for families and youth in recovery. Additionally, as the only tribal representative at the consultative session, she stated that the substance abuse treatment field needs to be more cognizant of disparities and become more culturally inclusive.

To build a responsive recovery-oriented system of care the cultural lens of the community needs to be used and family and youth leadership supported. Throughout, there needs to be individualized planning, project management and staff, key family contacts, parent support networks, social marketing, and evaluation efforts. To initiate the work of developing a recovery-oriented system of care, Ms. CrossBear encouraged leaders to start where they are and concentrate on the 4 Cs: constituency representation, credibility in the community, capacity to engage others, and commitment to difficult work.

Panel 3: Community Perspectives

A Community Partnership Recovery-Oriented Model

Dennis Noonan, M.S.W., L.C.S.W., Clinical Director
Pima Prevention Partnership, Tucson, Arizona

Mr. Noonan presented a model of a recovery program designed and operated by his agency, a community-based substance abuse treatment provider. The Pima Prevention Partnership developed the Sin Puertas Outpatient Services program to create an alternative to the youth drug culture. At the time of the recovery consultative session, it was the only youth recovery program funded by SAMHSA. The program is located approximately 70 miles from the Mexican

border, and a majority of youth entering substance abuse treatment at Pima are Hispanic. The Partnership receives most of its referrals through the juvenile justice system.

The Pima Prevention Partnership emphasizes multiagency collaboration by establishing relationships with other Tucson child-serving agencies. Each agency relationship is individualized by using common goals based on the relevant outcomes for the specific child-serving system.

Mr. Noonan explained that prior to referral to treatment, child-serving agency staff screen youth using the Global Appraisal of Individual Needs (GAIN) screening instrument. If the screen indicates that a youth should continue to assessment, an intake meeting is scheduled with the youth and family to prepare the youth to enter substance abuse treatment. A multidisciplinary team reviews the results of the substance abuse and mental health assessment, any relevant court documents, and the family screening. An appropriate community-based substance abuse treatment service option is selected.

Mr. Noonan emphasized that the Pima Prevention Partnership considers all youth entering treatment to have co-occurring substance use and mental health disorders. Pima offers an array of treatment options, including Motivational Enhancement Therapy/Cognitive Behavioral Therapy-5 (MET/CBT-5), Adolescent Community Reinforcement Approach (ACRA), day support services, and a co-occurring substance use and mental health disorder program. The agency also provides case management, tracking services, and an aftercare referral service.

Sensing a need for additional recovery support services beyond traditional aftercare or post-substance abuse treatment step-down services, Pima Prevention Partnership created FREEMIND, a recovery community network of youth and adults in support of youth who have experienced a life of substance abuse or mental health problems. FREEMIND creates a positive, drug-free, and supportive living environment by recognizing the specific needs of these youth. Treatment completion is not a criterion for FREEMIND membership.

In the FREEMIND model, youth plan and conduct sober activities and events at various school and youth recovery sites. Members utilize technologies including blogs, cyber cafes, Web sites, Web casts, and newsletters to meet youth where they are. FREEMIND also offers \$1,000 grants to youth to develop, plan, and operate sober, community-based activities. Mr. Noonan stressed the importance of new media in recovery support for youth and urged substance abuse treatment providers and government to embrace technology to engage youth.

Adolescent Recovery: Community Perspectives

Angelo Adson, M.S.S., M.L.S.P., M.B.A., L.C.S.W., Clinical Administrator
Intercultural Family Services, Philadelphia, Pennsylvania

Mr. Adson directs a community-based recovery-oriented system of care in Philadelphia, Pennsylvania. He addressed the need for substance abuse and mental health treatment system integration. He initiated his presentation by addressing the commonalities between the substance abuse and mental health treatment systems. He challenged the audience to identify the aspects of these systems that will nurture the development of an integrated recovery-oriented system of care for youth. To set the context, Mr. Adson stated that even in integrated child-serving systems adolescents and/or families with substance use problems are often criminalized. For urban youth in recovery limited supports often exist and youth are often criminalized, pathologized, or isolated with a “blame the victim or parent” mentality. Many youth access substance abuse services through the juvenile justice system. They also receive poorly

integrated substance abuse and mental health treatment and suffer poor outcomes, which may lead to a sense of systemic hopelessness.

Mr. Adson reinforced that trauma on the individual, family, and community levels needs to be recognized. Systemic abuse exacerbates personal trauma experienced by adolescents. Mr. Adson stated that traumatized youth are often labeled, misdiagnosed, and disrespected, which leads to further traumatization. Systemic abuse in substance abuse treatment often exacerbates externalizing mental health disorders. Families are blamed and consequently feel isolated and disempowered. The current substance abuse treatment system suffers from cultural insensitivity and an overuse of ethnic labels. Mr. Adson stated that there is poor recognition of historical, cultural, and personal trauma as well as poor integration of spiritual, community, and personal resources. He believes that the culture of “once an addict, always an addict” pervades the current substance abuse treatment system.

Mr. Adson believes that “silos” prevent child-serving agencies from coordinating, which causes each child-serving agency to develop treatment and recovery services and supports in isolation.

To begin integrating the work of child-serving agencies, including mental health, substance abuse, and juvenile justice, he feels that society needs to classify adolescents as a vulnerable population requiring developmental consideration; exercise a high level of respect for individuals, families, and the subsystems that sustain them; exercise full integration of mental health and substance abuse treatment; and recognize and emphasize the impact of trauma on individuals, families, and communities. These points are even more important in disenfranchised communities. Mr. Adson emphasized that substance abuse treatment providers must respect the youth that they serve, and that this behavior must start from the top. Mr. Adson provided an example of a board of directors for a substance abuse treatment agency that invited adolescents to participate on the board. Adolescents provided guidance and helped to run the agency, which led to bolstering the adolescents’ sense of inclusion and importance. Mr. Adson noted that the agency has been successful thus far because youth and families have driven treatment. He acknowledged a need to further integrate the youth voice by incorporating a sense of hope into the provider’s organizational perspective.

Mr. Adson suggested beginning by integrating gender-specific models of care, especially for males of color to address labeling, grouping, and institutionalism. These models should recognize the etiology of addiction and acknowledge the importance of the money, power, and respect continuum. Individual, family and cultural strengths, and resiliency should be harnessed by these models. Additionally, the community should develop viable and accessible continuing care for youth. Mr. Adson stressed accountability and stated that youth cannot have better treatment outcomes until recovery-oriented systems of care are operationalized on a large scale.

Charge to the Group

Barbara Friesen, Ph.D., Director

Research and Training Center on Family Support and Children’s Mental Health, Portland State University, Portland, Oregon

Dr. Friesen introduced the format for the work sessions. She explained that planning committee members assigned participants to workgroups in advance in order to harness the diverse perspectives represented at the consultative session and that each workgroup would address the same topics/questions during the work session.

Dr. Friesen informed participants that they would discuss outcomes, values, and principles during the first day's work session. She asked participants to refer to SAMHSA's National Outcome Measures (NOMs) included in the participants' resource materials for the outcomes discussion. Dr. Friesen directed participants to Tables 1 and 2 of the resource materials to guide the values and principles work session component (see Appendix H).

Day 2: Opening Remarks

Doreen Cavanaugh, Ph.D., Research Associate Professor
Health Policy Institute, Georgetown University, Washington, DC

Dr. Cavanaugh welcomed participants to the second day of the consultative session on designing a recovery care model for adolescents and transition age youth with substance use or co-occurring mental health disorders. She thanked participants for their work on the first day and reflected on major points from the presentations. She reviewed the working assumptions, referred to the compelling data supporting the need for recovery support, and underscored the essential messages from the youth, family, and community perspectives.

Dr. Cavanaugh previewed the program for the second day, noting that the directors of SAMHSA's CMHS and CSAT would address the group. She commented that this clearly indicated the importance of recovery issues at SAMHSA. She looked forward to the panel on models of recovery support, which demonstrates how much could be accomplished with vision and leadership, and concluded by welcoming Director Power.

Morning Keynote

A. Kathryn Power, M.Ed., Director
Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, Rockville, Maryland

Ms. Power opened the second day of the consultative session by stating that she was pleased to begin crafting language around a recovery-oriented system of care for youth that can be employed by both the substance abuse and mental health fields. At the 2004 National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation, mental health consumers, family members, providers, advocates, researchers, academicians, managed care representatives, accreditation organization representatives, and State and local public officials created a consensus statement on mental health recovery, which states that "Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential." Since then the mental health field has continued to move briskly forward with the concept of recovery at the center of systems of care.

Ms. Power went on to state that there are a number of values and principles associated with recovery. As an integrated field, mental health and substance abuse need to think about how and why these values should be associated with young adults. It is important to align the language used with the values and principles shared across SAMHSA and determine recovery components by consensus. Ms. Power highlighted the 10 fundamental components of recovery as defined by the National Consensus Conference participants and recommended them for more thoughtful consideration by the recovery consultative session participants working on behalf of youth with substance use and co-occurring mental health disorders:

- *Self-Direction*: Recovery must be self-directed with each individual defining his/her own life goals. Consumers lead, control, exercise choice over, and determine their own paths to recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life;
- *Individualized and Person-Centered*: There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his/her needs, preferences, experiences, and cultural background. Treatment and recovery systems should be individualized and strengths-based;
- *Empowerment*: Consumers are educated and have the authority to choose from a range of options and to participate in all decisions that affect their lives. They have the ability to effectively speak for themselves about their needs, wants, desires, and aspirations. Individuals gain control over their own destinies and influence the organizational and societal structures in their lives;
- *Holistic*: Recovery as a holistic approach focuses on total wellness and encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health, health-care treatment and services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports. For youth an emphasis on natural supports is especially important;
- *Nonlinear*: The nature of recovery is nonlinear. Recovery is based on continual growth, occasional setbacks, and learning from experience. While illness and the management of illness becomes a part of the nonlinear journey, recovery begins with an initial awareness that positive change is possible which enables the consumer to fully engage in the work of recovery;
- *Strengths-Based*: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. The process of recovery moves forward through interaction with others in supportive, trust-based relationships. A resiliency-based definition of recovery is helpful;
- *Peer Support*: Mutual support, including the sharing of experiential knowledge, skills, and social learning, plays an invaluable role in recovery. Consumers encourage and engage others in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community. For youth engaged in social learning through technology, employing new media is fundamental to building resiliency and recovery;
- *Respect*: Respect ensures the inclusion and full participation of consumers in all aspects of their lives. Appreciation of consumers and societal acceptance in the community and treatment systems are crucial to achieving recovery. Self-acceptance and regaining belief in one's self are vital. Youth may experience disrespectful situations when seeking care. Thus between consumers and professionals mutual respect must be emphasized;
- *Responsibility*: Consumers must take personal responsibility for their own self-care and journeys of recovery. Consumers must demonstrate courage and must strive to understand their experiences and identify coping strategies and healing processes to promote their own wellness. There is a need to better define and refine the concept of "responsibility" for youth; and,
- *Hope*: Hope is the catalyst of the recovery process. Recovery provides the essential and motivating message of a better future. People can and do overcome the barriers

and obstacles that confront them. Hope must be internalized, but it can be fostered by peers, families, friends, and providers.

Ms. Power indicated that hope is her litmus test for an effective system. Hope should be at the core of recovery as the most fundamental characteristic embedded into every aspect of treatment and services. The definition of a recovery-oriented system of care must lend itself to a belief in the future despite the level of disability or severity of the problem. Ms. Power stated that today's consultative session is the door-opener to a new world of thinking about co-occurring disorders and concluded that this is the time to build a recovery-oriented system of care for youth.

Panel 4: System, Service, and Support Issues: Lessons Learned

Cuyahoga County

Patrick Canary, M.Ed., Director

Center for Innovative Practices, Institute for the Study of Prevention of Violence, Kent State University, Cleveland Heights, Ohio

Mr. Canary reviewed the characteristics of Ohio youth with substance use and co-occurring mental health disorders and discussed a treatment model developed by the Center for Innovative Practices to address this population.

Mr. Canary stated that for youth co-occurring substance use and mental health disorders are heterogeneous and complex. The severity, complexity, and mix of externalizing and internalizing mental health disorders and substance use symptom patterns can vary among adolescents. The characteristics of co-occurring disorders have multiple affects on youth, family resources, and the youth's treatment potential. Often youth with co-occurring substance use and mental health disorders are involved in multiple child-serving systems.

Mr. Canary identified four items to consider in the development of a treatment model for youth with substance use and co-occurring mental health disorders:

- Implement an integrated approach to recovery that considers substance use, mental health disorders, and contextual factors as primary, interrelated components of a youth's recovery;
- Regard adolescent recovery on a developmental continuum from early adolescence through transition age youth;
- Collaborate across child-serving systems and include mentors, family members, and other key supports; and,
- Tolerate multiple substance use and co-occurring mental health treatment episodes as a part of recovery.

Individuals in the 12–25 age range pose specific challenges based on their age and developmental stage. Adolescents aged 12–18 often have less developed executive functioning, which may lead to poor self-regulation and impulse control. Mental health problems often predate substance use in this population. Adolescents have emerging substance use disorders, which are not as established as adult substance use patterns. Often adolescents have contact with multiple child-serving systems, and this may affect access to substance abuse and mental health treatment services.

Transition age youth 18–25 years old often deal with adult real world demands and challenges (i.e., employment, housing, benefits, etc.) with adolescent skills. Substance use patterns among transition age youth solidify and mental health patterns become more established. Internal factors motivate more substance use. Connections to child-serving agencies end and frequently youth do not qualify for services in adult systems.

Because adolescents and transition age youth cope with distinct challenges, Mr. Canary suggested using a resiliency-recovery developmental continuum framework based on the age and developmental stage of the youth. In early adolescence (around ages 12–14), resiliency and focusing on developing and building protective factors should be emphasized. As the individual moves through the developmental frame and becomes more interdependent, recovery should be prioritized. Recovery should aim to rebuild and maintain protective factors. A resiliency and recovery focus can provide meaningful resources and supports for the youth and family, offer strong asset building opportunities, and provide school and vocational supports. Mr. Canary considered the wraparound model ideal for developing an ongoing service and support plan for the youth and family.

The Center for Innovative Practices piloted an Integrated Co-Occurring Treatment (ICT) model in Ohio. ICT expects that youth will need ongoing services, supports, and monitoring beyond the clinical core of substance abuse and mental health treatment. The model focuses on developing community linkages, monitoring families, and providing informal supports. ICT providers actively identify and connect youth and family members to continuing care services, supports, and follow-up. Youth can access clinical booster sessions if necessary.

ICT collaborates with key child-serving system partners including juvenile justice, education, and child welfare. System partners screen and assess youth to identify youth with early substance use and/or mental health disorders. Teams meet regularly to ensure that each child-serving system's response aligns with the youth's treatment plan. Evaluation of youth in the Strengthening Communities for Youth (SCY) project in Cuyahoga County (Cleveland) Ohio, conducted by the Institute for the Study and Prevention of Violence at Kent State University, would indicate that the opportunity for successful intervention goes down with each subsequent treatment episode, thus it is important to improve identifying needs in an accurate and timely manner so that the initial interventions are the "right" type in the "right dosage" for the "right" youth.

Mr. Canary reviewed several recommendations from his experience during the ICT pilot including:

- Align policy outcomes across public entities, providers, and funders;
- Establish youth with substance use and co-occurring mental health disorders as a priority treatment population;
- Create an infrastructure that supports integrated treatment;
- Create funding streams that support integrated treatment;
- Identify cross-system shared outcomes; and,
- Dedicate resources to support research and evaluation.

Beth Dague, M.A., Director

Cuyahoga County, Tapestry System of Care, Cleveland, Ohio

Ms. Dague discussed how one county developed an SOC model. In 2004, Cuyahoga County (Cleveland) identified approximately \$610 million spent on services for youth and families, and

that approximately seven percent of youth and families served accounted for one-third of the county's expenditures. This finding prompted the country to realign its child-serving systems.

Cuyahoga County applied for a CMHS (SAMHSA) SOC grant. SOC creates a partnership between child-serving agencies including mental health, substance abuse, child welfare, juvenile justice, and education to provide services and supports to youth and their families with mental health disorders. Cuyahoga County had also applied for a SCY grant from CSAT (SAMHSA). CSAT developed SCY grants to "develop linkages and networking mechanisms throughout the community to facilitate identification, assessment, referral, and treatment of youth with substance abuse problems and their families" (CSAT, 2001).

Sensing an opportunity to build a public infrastructure supportive of systems of care, Cuyahoga County requested permission to combine the SOC and SCY grants, which SAMHSA approved. Cuyahoga County invited the business community, the United Way, and private foundations to participate in its SOC initiative.

After establishing relationships with providers, Cuyahoga County initiated a series of reforms to build a system of care. The county created family teams and required substance abuse/mental health treatment providers to offer wraparound services. Cuyahoga County established neighborhood settlement houses and provided substance abuse and mental health treatment services in these settings. To share information across partners, Cuyahoga County developed an information technology system for all funders, treatment providers, and system partners. Data from this system were shared with the entire community. Ms. Dague reported that these infrastructure changes have created a lasting impact on youth substance abuse and co-occurring mental health treatment services in Cuyahoga County.

Detroit Recovery-Oriented Systems of Care

Calvin Trent, Ph.D., Director

Division of Special Health Populations, Detroit Department of Health and Wellness Promotion, Detroit, Michigan

Dr. Trent spoke about how Detroit developed a recovery-oriented system of care for adults (ROSC) in their community. In 2003, Detroit applied for and received a CSAT Recovery Community Support Program (RCSP) grant, which provided the impetus for the community to begin transforming the substance abuse treatment system from a traditional treatment centered approach to a recovery centered approach. Dr. Trent stated that the two foundational elements to this recovery-oriented system of care were an abundance of recovery capital with a strong, vibrant, and vocal community and a cooperative State system, which permitted Detroit to operate more like a county. Detroit's substance abuse agency supported the city's efforts to build a recovery-oriented system for adults and created an administrative rule allowing recovery services to be funded with substance abuse treatment dollars.

Dr. Trent defined the key elements of Detroit's recovery-oriented system of care as:

- Offering a comprehensive menu of services and supports that can be combined and readily adjusted to meet the individual's needs and chosen pathways of recovery;
- Encompassing and coordinating the operation of multiple systems, providing responsive, outcomes-driven approaches to care;
- Providing access to recovery services for all irrespective of the selected pathway;
- Allowing the individual to be the principal developer of his/her recovery plan; and,

- Making recovery supports available continuously.

William L. White, M.A., and Mark Sanders, L.C.S.W. encapsulate the thinking in Detroit. “A major focus of a recovery-oriented system of care is to create the physical, psychological, and social space within local communities in which recovery can flourish. The ultimate goal is not to create larger treatment organizations, but to expand each community’s natural recovery support resources.” Dr. Trent stated that once substance abuse treatment providers recognize the implications of this idea, they want to participate in the process of building and strengthening the system.

The three primary components that make up the recovery system’s provider network in Detroit include:

- Traditional clinical substance abuse treatment providers that are part of the coordinating agency network;
- Nontraditional recovery support providers that include the Detroit Recovery Project, a 501(c)(3) community-based organization spun off from the original RCSP grant run by people in recovery for people in recovery, and TAPS, where peers work to engage with individuals in treatment to involve them in longer-term recovery; and,
- Community-based organizations that include faith-based programs, 12-Step groups, mental health, social services, housing, and employment formed through a cooperative agreement with the Department of Human Services as the coordinating body.

With the community demanding the substance abuse treatment system provide treatment widely and immediately, Detroit used existing funds to create an 800 number to provide access to substance abuse treatment services on demand with transportation available to pick up the person the same day.

Detroit’s recovery-oriented system of care encompasses and coordinates the operations of multiple service systems supporting the individual, family, and community in the domains of health, wellness, and recovery. As such, Dr. Trent stated that the challenge is to bring these services together in a coordinated and meaningful way. Regardless of the pathway to recovery an individual chooses, the substance abuse treatment system is required to provide services and apply a chronic care model recognizing that recovery is a lifetime process not an acute situation.

Although Detroit is working hard to implement a recovery-oriented system of care, Dr. Trent noted that there are still questions to consider regarding adolescents and recovery. In particular, “How does Detroit conceptualize recovery for young people? To what extent can Detroit conceptualize peer supports for young people? Who does Detroit see as providing peer support for young people? How should the adult recovery community be involved? What role should parents/guardians play in recovery services for young people? What institutions need to be created or expanded to support young people in recovery? Are there policies that need to be addressed or written in order to facilitate recovery support for young people?” Although the community has begun the work of building a recovery-oriented system of care, Dr. Trent concluded that there are many more questions to answer and more work to do.

Charge to the Group

Doreen Cavanaugh, Ph.D., Research Associate Professor
Health Policy Institute, Georgetown University, Washington, DC

Dr. Cavanaugh charged the recovery consultative session participants to identify the services, supports, and infrastructure elements most important to a recovery-oriented system of care for youth. Dr. Cavanaugh asked participants to use three sources to inform their deliberations: 1) the recovery consultative session resource materials, 2) the speaker presentations, and 3) a summary of the consultative session's proceedings from the first day.

Dr. Cavanaugh acknowledged the current state of treatment for youth with substance use or co-occurring disorders and the significant effort needed to assure State/community readiness to provide all of the services, supports, and infrastructure necessary for a recovery-oriented system of care. She reminded participants to capture challenges and opportunities for recovery-oriented systems of care as they emerged during work session deliberations. Dr. Cavanaugh closed the charge by urging attendees to be comprehensive in scope and detailed in recommendations. She said that their work would assist SAMHSA, States, and communities in designing and implementing recovery systems, services, and supports for youth.

Luncheon Keynote

H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM, Director
Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, Rockville, Maryland

Dr. Clark thanked participants for attending the recovery consultative session and stressed the importance of providing treatment and care to adolescents and transition age youth with substance use and co-occurring mental health disorders. Dr. Clark stated that youth experience significant developmental changes throughout adolescence, including brain maturation, endocrine changes, increased risk taking, sexual and romantic interest, and environmental changes. These biological, physical, and environmental factors affect adolescents at different developmental stages but can lead to risky decision making.

Dr. Clark presented data on the adolescent population from the 2007 NSDUH and the 2007 Monitoring the Future (MTF) study. Both surveys found increasing levels of alcohol use as an adolescent ages. The 2007 NSDUH reported that 14.7 percent of 14- and 15-year-olds used alcohol in the past month while the 2007 MTF study found 15.9 percent of 8th graders indicating past month alcohol usage. Among 12th graders the 2007 MTF study documented 44.4 percent reporting past month alcohol usage. The 2007 NSDUH estimated that 50.7 percent of 18- to 20-year-olds used alcohol in the past month.

Data from the 2002–2003 NSDUH estimated that 8.9 percent of adolescents are classified as dependent or abusive of alcohol or illicit drugs. This represents a 27-percent increase from 1995. In 2007, 9.5 percent of adolescents aged 12 to 17 reported using illicit drugs in the past month according to NSDUH. Marijuana remained the most popular illicit drug among adolescents with 6.7 percent reporting past month usage in 2007. Adolescents also experience co-occurring substance use and mental health disorders. The 2007 NSDUH found that 18.9 percent of adolescents aged 12–17 who reported the occurrence of a major depressive episode in the past year also had illicit drug and alcohol dependence or abuse, as opposed to 6.7 percent of 12- to 17-year-olds not reporting a past year major depressive episode.

Dr. Clark used data from SAMHSA's Treatment Episode Data Set (TEDS) to examine trends in adolescent substance abuse treatment admissions from 1993 to 2003. Dr. Clark found that adolescent substance abuse treatment admissions increased 61 percent over the time period. Increased referrals from the juvenile justice system drove this increase. Referrals to substance abuse treatment from the juvenile justice system increased 115 percent from 1993 to 2003, and in 2003 accounted for 53 percent of all adolescent substance abuse treatment referrals. While treatment admissions have increased from 1993 to 2003, most adolescents in need of treatment do not receive it. Dr. Clark stated that 2007 NSDUH data indicate that 1.8 million adolescents classified as dependent or abusing alcohol or illicit drugs did not receive any public or private substance abuse treatment, and of that number, 96.9 percent did not feel they needed treatment.

Dr. Clark indicated that the recovery process must be facilitated. CSAT sponsored a National Summit on Recovery in 2005 that defined recovery as "...a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life." Dr. Clark stated that adolescent and transition age youth face several barriers to recovery from substance use disorders. These include a lack of individualized/appropriate care during treatment, lack of post-treatment follow-up, lack of access to resources, return to nonsupportive environments, failure to address trauma or sexual histories, and maintenance of past peer networks. Transition age youth may face leaving the foster care system, becoming parents, decreased availability of safety net services, and often difficulty meeting the criteria for receiving adult services.

A recovery-oriented system of care approach shifts the emphasis from how to engage an individual into treatment to how to support the longitudinal process of recovery within the person's environment. It should support person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families, and communities to take responsibility for their sustained health, wellness, and recovery from alcohol and drug problems. It offers a comprehensive menu of services and supports that can be combined and readily adjusted to meet an individual's needs and chosen pathway to recovery and views a substance abuse treatment agency as one of many approaches needed for an individual to integrate successfully into the community. Various supports work in harmony under the direction of the individual so that all possible resources work for and with the individual in recovery. Dr. Clark indicated that benefits to a recovery-oriented system of care approach include responding more effectively to individuals, families, and communities; providing a framework for structuring policy development and planning; and applying knowledge gained from recovery-oriented research. He emphasized that the recovery-oriented system of care approach to adolescent treatment recognizes the importance of including resources that address the biological, cognitive, and emotional changes that influence psychological functioning and impact an adolescent's successful recovery from substance abuse. While the Federal government plays a role in recovery-oriented systems, the approach must be much larger to encompass State, local, community-based, and faith-based supports, services, and systems.

Dr. Clark advocated for the development of a recovery-oriented response model that would provide continuous substance abuse treatment response as symptoms increased while also promoting self-care and rehabilitation. Over time, the continuous treatment services provided would reduce symptom spikes and the adolescent would be able to move into a recovery zone.

Results of the Consultative Session Discussion Groups

Throughout the course of the two-day meeting attendees were assigned to one of four discussion groups to identify the most important elements of a recovery-oriented system of care for youth.⁶ Participants endorsed priorities in several areas: values and principles; services and supports; infrastructure necessary for the development and operation of an effective system; and outcomes at the individual, family, and system levels. Discussion group participants identified a universe of elements related to each topic, prioritized the five most important elements through a group forced choice process, and reported those priorities in plenary sessions. This section of the report summarizes the priorities from these discussion groups. The authors employed qualitative methods to analyze the results. Discussion group content was reviewed and clustered; common themes were identified; and items were then weighted, arrayed, and listed under thematic headings. In this document key concepts are identified and supporting elements prioritized by two or more groups are reported.⁷

Values and Principles

Values and principles form the foundation of the design, architecture, and implementation of a recovery-oriented system of care. Table 1 identifies the values and principles endorsed by two or more recovery consultative session discussion groups.

All of the discussion groups stressed the importance of designing a family-focused recovery system. Participants urged employing a broad definition of family which might include biological, adoptive or foster parents and their partners, grandparents, siblings, other kinship caregivers, friends, and others as defined by the youth. Participants cited the value of family involvement and including the family in treatment. Participants urged assuring that the system should be responsive to families, that the unit of care should be the family, and that family voice should permeate the entire youth treatment and recovery system. The majority of the discussion groups also

emphasized the need to design a youth-focused and age-appropriate recovery system that reflects developmental stages of adolescence and transition age youth. Participants stressed that applying adult models to an adolescent population may not be effective. Two of the four groups emphasized the need to recognize the dynamic, nonlinear nature of recovery and the importance of building a model that promotes resilience, is strengths based, supports youth empowerment, and identifies the recovery capital both within the youth and his/her environment.

Table 1: Values and principles endorsed by two or more recovery consultative session discussion groups

- Being family focused;
- Employing a broad definition of family;
- Being age appropriate;
- Reflecting the developmental stages of youth;
- Acknowledging the nonlinear nature of recovery
- Promoting resilience;
- Being strengths based;
- Supporting youth empowerment; and,
- Identifying recovery capital.

⁶ See Appendixes C, D, and E for the consultative session agenda, participant list, and discussion questions.

⁷ For more detail, see Appendixes E, F, and G.

The groups also identified other values and principles to include in a recovery-oriented system of care. These elements are listed in Table 2 below.⁸

Table 2: Values and principles prioritized by at least one of the recovery consultative session discussion groups

- Empowering youth/consumer;
- Being youth guided;
- Being individualized;
- Promoting hope;
- Emphasizing accessibility;
- Providing choice;
- Containing a broad array of services and supports;
- Being culturally competent;
- Promoting individual responsibility;
- Being integrated;
- Using an ecological approach;
- Providing continuity of care;
- Engaging youth;
- Being nondiscriminatory;
- Being collaborative;
- Being cost-effective; and,
- Promoting authenticity.

Services and Supports

In this section discussion group participants identified what they considered the most essential services and supports to be included in a recovery-oriented system of care for youth. Table 3 identifies the services and supports endorsed by two or more recovery consultative session discussion groups.

Continuing the theme of the importance of family, all of the groups cited the need for ongoing family involvement. Examples included family and parent support and counseling and the use of family teams. All of the groups also endorsed the importance of linkage to services, stressing continuity of care, a long-term perspective for the recovery system, and a continuing care focus including multiagency teams, coordination of services, and care management. All of the groups also supported assuring that the range of services and supports address multiple domains in a young person's life. Examples

Table 3: Services and supports endorsed by two or more recovery consultative session discussion groups

- Ensuring ongoing family involvement;
- Providing linkage to services;
- Assuring that the range of services and supports address multiple domains in a young person's life;
- Including services that foster social connectedness;
- Providing specialized recovery supports; and,
- Providing therapeutic/clinical interventions.

⁸ For additional information on values and principles, see Appendix F, pp. 66–70.

of services and supports that the majority of the groups recommended included life skills training, vocational training and assistance, recreational opportunities, social supports and transition planning, housing assistance, leadership development, and recovery high schools/colleges. Two groups identified the need for services and supports that foster social connectedness, such as mentors, and the use of specialized recovery supports, such as electronic media and internet based tools. Two of the four groups also stressed the importance of a clinical core of therapeutic/clinical interventions.⁹

Infrastructure

Participants identified several infrastructure elements that they considered essential to the design and implementation of effective youth recovery-oriented systems. Table 4 identifies the infrastructure elements endorsed by two or more recovery consultative session discussion groups.

All of the groups endorsed the concept of family involvement at the design/policy level. Examples included infrastructure support for youth/family advocacy and family/professional partnerships that assure youth and family members' full participation in decision- and policy-making roles at all levels. The majority of groups prioritized essential overarching policy changes at Federal, State, and provider levels to support and operationalize a recovery-oriented paradigm shift. Participants urged employing collaborative financing mechanisms, including braiding or blending multiple funding streams, as well as collaboration and integration across all youth-serving systems on the conceptualization, design, and planning of a recovery-oriented system of care. Workforce development issues were highlighted as well as identifying emerging competencies and new roles needed in a recovery-oriented system. Participants emphasized challenges that are inherent in the implementation of a new system design, stressing the need for leadership development. Two groups identified as priorities the importance of accountability, including the development and implementation of quality assurance practices and performance measurement and monitoring for traditional and nontraditional providers.¹⁰

Table 4: Infrastructure elements endorsed by two or more recovery consultative session discussion groups

- Family involvement at the design/policy level;
- Policy change at the Federal, State, and provider levels;
- Collaborative financing;
- Collaboration and integration across all youth-serving systems;
- Workforce development;
- Leadership; and,
- Accountability.

⁹ For additional information on services and supports, see Appendix F, pp. 71–73.

¹⁰ For additional information on infrastructure, see Appendix F, pp. 74–76.

Outcomes

The most important outcomes for youth endorsed by half of the groups (see Table 5) were youth social connectedness; increased capacity of youth to give back to the community, including peer to peer opportunities; increased self-sufficiency; and an increase in each youth's developmental assets. At the family level half of the groups endorsed family (including sibling) recovery and the ability of adults to be supportive of youth in recovery. At the systems-level participants urged easy access into the service system through multiple entry points.¹¹

Table 5: Outcomes endorsed by two or more recovery consultative session discussion groups

Youth

- Social connectedness;
- Reciprocity: increased capacity of youth to give back to the community;
- Increased self-sufficiency; and,
- Increased number of developmentally appropriate assets.

System

- Support for family and sibling recovery; and,
- Easy access to service system through multiple entry points.

¹¹ For additional information on outcomes, see Appendix F, pg. 77-78.

Challenges

As part of the deliberations of the consultative session, participants identified challenges to developing recovery-oriented systems of care for youth. Because of limited time devoted to the discussion, this list of challenges is neither comprehensive nor in-depth; however, it does provide an overview of major themes and some of the specific issues that emerged. The statements below reflect the views of the participants.

Theme 1: Lack of a shared language and common vision

- There is no shared language across service systems to articulate a common vision of recovery-oriented systems of care.

Theme 2: Complexity of achieving change

- There is difficulty conceptualizing and integrating change;
- Many people are afraid of paradigm shifts;
- There is often resistance to changing organizational culture in Federal, State, and local bureaucracies; and,
- Special interests tend to want to continue business as usual.

Theme 3: Stigma

- In the general public there is denial and a lack of understanding of behavioral health issues, services, and supports.

Theme 4: Disparities across race, ethnicity, culture, age, and gender

- These are disparities in access, appropriateness, and quality of care which need to be addressed.

Theme 5: Cultural and linguistic competence

- In many communities there is a lack of diverse programming to meet the needs of different population groups; and,
- Currently age, gender, race, culture, diagnosis, etc. do not always inform the development of appropriate services and supports.

Theme 6: Youth and family involvement and leadership

- Leadership roles are often new for families and youth; and,
- There is a lack of services, supports, training, and infrastructure to enable involvement of youth and family leaders.

Theme 7: Lack of infrastructure supporting integrated systems of care and recovery

- There is a need to infuse recovery principles in all aspects of the infrastructure; and,
- The informal nature of a recovery-oriented system of care challenges regulatory and accountability systems.

Theme 8: Financing

- There is a lack of funding to serve and address the multiple and complex needs of families and youth;
- There is inadequate funding for the services and supports needed in a recovery-oriented system of care for youth;
- Financing mechanisms are often neither comprehensive nor flexible; and,
- The current financial and economic crisis in this country is a challenge.

Theme 9: Service system coordination

- The systems that need to be a part of a recovery-oriented system of care are fragmented and siloed.

Theme 10: Outcomes and accountability

- There is a lack of accountability and measurement of appropriate outcomes at both the system and individual levels.

Theme 11: Workforce capacity

- There is a lack of common understanding and knowledge of recovery-oriented systems of care on the part of professionals;
- There is a lack of adequate and appropriate training for the behavioral health workforce; and,
- Worker roles are not well defined.

Theme 12: Services and supports

- A recovery-oriented system of care needs to include a menu of options for youth; these services and supports are often lacking; and,
- The lack of services and supports results in delays for youth in need of care.

Theme 13: Care coordination

- There is fragmentation of care at the individual level; and,
- There is a lack of clear definition of the functions of care coordinators.

Theme 14: Confidentiality

- There is a tension between protecting the privacy rights of the individual and facilitating service coordination and collaboration.

Theme 15: Statewideness

- The vision and policy focus of a recovery-oriented system of care must be at the State level; and,
- There are few models of developing and operationalizing recovery-oriented systems of care statewide.

Theme 16: Research and knowledge dissemination

- There is a lack of research and knowledge dissemination on recovery-oriented systems of care and what is necessary to ensure effectiveness.

Opportunities

The consultative session participants also identified opportunities for developing recovery-oriented systems of care. They observed that challenges and opportunities often correspond; what is a challenge may also be viewed as an opportunity for change and action. The following themes capture participant viewpoints expressed during the time-limited group discussion.

Theme 1: Growing awareness of issues and problems

- There is a growing awareness about substance abuse and mental health problems of adolescents and transition age youth and recognition of co-occurring disorders and related issues.

Theme 2: Pockets of excellence and promising practices

- Promising and best practices for services and supports within a recovery-oriented system of care exist;
- With pockets of excellence emerging across the country, there are also opportunities to expand programs and bring them to scale; and,
- Models that have been effective can be adapted across the country to address the youth population and local needs.

Theme 3: Linkage to public and private sector funding

- There are funding possibilities to support collaborative approaches to service delivery; and,
- SAMHSA grant programs including State Adolescent Substance Abuse Treatment Coordination (SAC), SCY, RCSP, and SOC provide examples of Federal opportunities to help build recovery-oriented systems of care.

Theme 4: Community resources

- There are multiple formal and informal resources including schools and faith-based organizations to support recovery-oriented systems of care.

Theme 5: Emerging technologies

- Emerging technologies provide innovative approaches to care, outreach, and support for young people.

Recommendations

The consultative session participants made recommendations for action at both the Federal and State levels for designing and implementing a recovery-oriented system of care for youth. This list does not reflect a comprehensive set of recommended actions or group consensus but rather a diversity of perspectives from the meeting participants. The recommendations cluster around a number of key themes relevant to Federal and/or State actions including:

- Integration;
- Financing Strategies;
- Family and Youth Involvement;
- Disparities and Cultural Competence;
- Services and Supports;
- Sustainability and Implementation;
- Public Awareness;
- Research; and,
- Technical Assistance.

Theme 1: Integration

Federal Level

- Improve integration across substance abuse, mental health, and other Federal youth-serving agencies;
 - Engage top level leadership; and,
 - Increase integration among Federal agencies utilizing a range of levers including:
 1. Legislative mandates requiring collaboration;
 2. Memorandums of Understanding (MOUs);
 3. Mechanisms to foster dialogue between and across systems;
 4. Collaboration/coordination across Federal technical assistance centers that support recovery; and,
 5. Request for Applications (RFAs) incorporating language to encourage collaboration.
- Improve integration between substance abuse and mental health agencies;
 - Identify areas of agreement and acknowledge where differences in philosophy, values, principles, and practice exist across the SAMHSA substance abuse and mental health treatment centers. Recognize and accept differences but build on commonalities;
 - Develop a shared definition of recovery;
 - Create a common taxonomy;
 - Provide cross-training opportunities; and,
 - Encourage dialogue.
- Support State and community substance abuse and mental health integration initiatives; and,
- Hold States accountable for integration; for example, foster integration in State plans (e.g., Medicaid, Substance Abuse Prevention and Treatment Performance Partnership Block Grant [SAPTPPBG] and Community Mental Health Services Performance Partnership Block Grant [CMHSPPBG]) mandated by Federal agencies.

State Level

- Streamline State bureaucracies;
- Increase collaboration among youth-serving State agencies and establish an interagency council at the State level for planning and coordination; and,
- Build State level staffing capacity across relevant agencies and youth services providers.

Theme 2: Financing Strategies

Federal Level

- Align Federal policy and funding for substance abuse and co-occurring mental health treatment and recovery support;
- Foster collaborative funding (braided/blended funding);
- Utilize Federal block grant funding and develop process to support recovery-oriented systems of care for youth; and,
 - Mandate that the SAPTPPBG and CMHSPPBG include set-asides for youth prevention, treatment, and recovery support; and,
 - Identify adolescents as a priority population for the CMHSPPBG and SAPTPPBG.
- Provide incentives to States to build recovery-oriented systems of care through grants to the States.
 - Support RFAs for States to develop recovery-oriented systems of care; and,
 - Award extra points in relevant RFAs that build recovery-oriented systems of care, including incentives to integrate substance abuse and mental health treatment systems.

State Level

- Develop a comprehensive financing strategy examining various funding streams;
 - Conduct financial mapping, analyze findings, and compile a list of resources that highlight State funding strategies to achieve and support recovery.
- Enhance use of Medicaid;
 - Involve relevant agencies in the development of the Medicaid State plan;
 - Take advantage of the broad opportunities available through Medicaid optional benefits (i.e. reimbursement for peer support);
 - Apply for Medicaid waivers and operationalize the possibilities under those waivers; and,
 - Encourage States to share information with each other regarding:
 1. Writing the Medicaid State plan;
 2. Determining which Medicaid waiver(s) to apply for; and,
 3. Increasing transparency so States know where to put their energy.
- Examine alternative revenue strategies; and,
 - Liquor taxes, for example, could serve as a revenue source.
- Encourage economic development.

Theme 3: Family and Youth Involvement

Federal Level

- Establish Federal funding for family and youth involvement; and,
- Identify Federal resources to support a commitment to family and youth voice.

State Level

- Integrate youth and family voice at all levels in the substance abuse and mental health systems. Invite and support youth and families to come to the table as partners.

Theme 4: Disparities and Cultural Linguistic Competence

Federal Level

- Develop policies that address and promote cultural and linguistic competence; and,
- Develop culturally appropriate outcomes to measure.

State Level

- Encourage State and tribal connections and initiatives to help address disparities.

Theme 5: Services and Supports

Federal Level

- Improve policies to facilitate the development, provision, and funding of recovery-oriented services and supports.

State Level

- Provide recovery services to youth;
- Develop State capacity plans to support nontraditional providers. Conduct more effective outreach to nontraditional providers;
- Recognize the need for developmentally appropriate services;
- Provide recovery-oriented care and aftercare;
- Use emerging models; and,
- Support data driven practices.

Theme 6: Sustainability and Implementation

Federal Level

- Use permanent statutory vehicles to ensure sustainability.

State Level

- Develop a comprehensive implementation approach for developing recovery-oriented systems of care, which will include public awareness, outreach, access, availability, capacity, and quality;
- Conduct outreach and encourage the development and implementation of recovery-oriented systems of care; and,
- Align licensure and administrative regulations to support recovery-oriented systems of care;
 - Conduct a Single State Agency (SSA) level review of all licensure and administrative regulations; and,
 - Revise licensure and administrative regulations as necessary to support recovery-oriented systems of care.

Theme 7: Public Awareness

Federal Level

- Create a Presidential Commission on youth substance abuse, co-occurring disorders, and recovery and develop a report similar to the New Freedom Commission report;
- Facilitate a national dialogue on recovery-oriented systems of care to raise awareness and gain clarity;
- Garner the attention of high-level leadership (i.e. executive-level leaders and advocates); and,
- Incorporate adolescents and transition age youth into national advocacy organizations.

State Level

- Involve new stakeholders. For example, invite business representatives to participate in policy and planning discussions.

Theme 8: Research

Federal Level

- Develop a research agenda on recovery-oriented systems of care;
- Build and validate the case for recovery-oriented systems of care using data;
- Connect data elements and review the information that is available;
- Improve dialogue between the National Institutes of Health (NIH) and SAMHSA;
- Simplify research findings and data so that youth and families understand the information; and,
- Conduct cost benefit analyses of recovery-oriented systems of care to facilitate paradigm shifts.

Theme 9: Technical Assistance

Federal Level

- Incorporate recovery into all SAMHSA technical assistance activities; and,
- Develop a central repository of information on recovery, resilience, and recovery-oriented systems of care.

Conclusions and Implications

This section highlights some of the observations and conclusions that the authors derived from the consultative session discussions. These observations have implications for next steps to build on the results of this work as well as for what it will ultimately take to develop recovery-oriented systems of care for all young people who need them.

The participants of the consultative session, as intended, represented a range of perspectives, including those of the substance abuse and mental health systems, families and young people, State and local administrators, providers, and researchers. Even given this diverse spectrum, the group demonstrated strong consensus and consistency on the values and principles of a recovery-oriented system of care, the services and supports essential to such a system, and the infrastructure necessary to support recovery-oriented systems of care nationwide. The values and principles identified aligned with those articulated by Stroul and Friedman (1986) for a system of care for children and youth at risk of or with serious emotional disorders, providing a basis for common ground between the mental health and substance abuse fields. This beginning consensus presents an opportunity to further the development of recovery-oriented systems of care across both the substance abuse and mental health fields, particularly for young people with co-occurring problems.

Although some young people may only need support from one system, overall the results of the consultative session deliberations, in conjunction with the findings from the literature review, affirmed that young people often have co-occurring substance use and mental health disorders. Commonalities exist in the array of services and supports that these young people need to address both their substance use and mental health disorders and to achieve positive outcomes. Consultative session participants also stressed that family and youth involvement in all aspects of service delivery is critical.

Participants conveyed that to achieve recovery-oriented systems of care will require a new mindset and transformation of systems and services, focusing not on problems but rather on engendering hope, optimism, and maximizing each young person's full potential. As a result, creating recovery-oriented systems of care will require changes in how the values and principles are incorporated, how people do business, and how services and supports are delivered in order to assure that they are family- and youth driven, culturally and linguistically competent, evidence informed, strengths based, and integrated. Treatment services and interventions need to be adapted to build in a recovery-oriented philosophy from intake through continuing care, modeling wraparound approaches.

The consensus on so many of the key elements of a recovery-oriented system of care for young people with substance use or co-occurring mental health disorders underscored the importance of creating holistic systems of care across all youth-serving agencies including but not limited to substance abuse, mental health, Medicaid, child welfare, juvenile justice, and education. While the primary focus of the meeting was on the design of recovery-oriented systems of care and the essential elements of such systems, the need for integration became a critical theme. It became clear that ultimately service systems must be integrated to realize a well-functioning recovery-oriented system of care. Participants stressed the importance of integrating youth-serving systems at the Federal, State, and community levels, as well as integrating individualized services and supports for each youth within those systems in order to attain comprehensive, coordinated, and holistic care. The system should be designed to meet the

needs of the individual and family in a flexible, integrated, collaborative, and outcome-focused model.

Discussions in the consultative session revealed that while there are many factors that serve as a foundation for common ground and for bringing substance abuse and mental health systems together, “turf” issues do exist and can serve as barriers. Participants often spoke either from a substance abuse or mental health orientation referring to “our providers,” “our services,” “our resources.” This current mindset perpetuates a fragmented delivery system and will require leadership and strategies to change thinking.

Participants of the consultative session noted that the fields of child and adolescent mental health and adolescent substance abuse have much to learn from each other. Many commonalities were identified; however, there are significant differences that need to be acknowledged. These differences include some of the unique aspects of treatment and support for specific substance abuse/mental health or co-occurring diagnoses. Systems are at different stages of development in a number of domains. The capacity and effectiveness of each system must be robust to adequately meet the needs of persons with substance abuse and/or mental health disorders as well as to provide a strong foundation for collaboration and increased integration between the systems.

The meeting did not focus on the development of an operational definition of recovery. However, participants representing young people, families, mental health systems, and substance abuse systems were able to agree on some similar concepts of recovery and what recovery means for young people with substance use or co-occurring mental health disorders. Shared concepts of recovery represent an important step in moving toward a more integrated system of care addressing both substance use and mental health. The dialogue and emerging consensus on values and principles begun at this meeting has provided the groundwork for development of a common vision and language.

While not the focus at this meeting, the recent passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 as well as current discussions on health-care reform may also provide opportunities for moving a recovery-oriented system of care agenda forward.

Next Steps

This Federal level endeavor represents a beginning collaboration across substance abuse and mental health focused on recovery as it applies to adolescents and transition age youth. Building on previous SAMHSA work, the consultative session advanced an understanding of essential elements of a recovery-oriented system of care for youth and what it will take to implement such systems in States and communities. The findings, however, only begin to lay the groundwork. Time was limited, the topics broad, and the process structured to identify highest priorities. Many critical issues, such as youth involvement, disparities, cultural competence, and stigma were not adequately addressed; but, the meeting provided a solid foundation for future work to be undertaken. It will be important for SAMHSA to continue this work to deepen understanding and operationalize concepts of recovery for young people and to promote better integration of substance abuse and mental health service systems.

The focus of this project was limited to youth with identified substance use or co-occurring mental health disorders who have been or were in treatment. Future work should expand beyond this focus to include prevention and promotion of resilience in all youth and to address the challenges associated with youth, especially those at risk, who do not come in contact with the treatment system.

The challenges, opportunities, and recommendations proposed by meeting participants provide some broad guidance on possible areas and strategies, particularly at the Federal and State levels, to further the development of recovery-oriented systems of care. These suggestions should be mined to determine the most feasible actions now.

The following areas are highlighted as possible priorities for future work to build on the foundation established through this project:

- Engage a much broader cross section of young people in affirming and further defining the essential elements of a recovery-oriented system of care;
- Develop a definition of individual recovery for adolescents and transition age youth that is endorsed by both the substance abuse and mental health fields and that incorporates concepts of resilience and positive youth development;
- Explore in greater detail some of the concepts that participants identified as being critical to recovery-oriented systems of care, including the nonlinear nature of recovery and recovery capital (i.e. how to build recovery capital for both the individual and the community);
- Examine more fully the concept of relapse as it relates to both adolescent substance abuse and mental health disorders;
- Further work to strengthen meaningful family and youth involvement in all levels of the systems at the practice, program, and policy levels;
- Address issues of disparities in the service system and examine how to ensure that recovery-oriented systems of care for youth are culturally and linguistically competent;
- Determine the most important and necessary core service components and supports that will enable young people to thrive in the community;
- Develop strategies for engaging important partners, such as businesses, to promote workforce opportunities and employment supports as a critical dimension of recovery for young people;

- Expand the focus to include prevention and early intervention strategies to promote resilience and recovery;
- Explore opportunities to implement some of the recommendations for Federal and State actions proposed by consultative session participants;
- Examine the steps to develop an integrated recovery-oriented system of care for young people with co-occurring substance use or mental health disorders; and,
- Assure that recovery support is an integral part of the implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and proposed health reform efforts.

Opportunities exist at the Federal, State, and community levels to expand the knowledge base and address these critical areas to improve the prevention, early intervention, treatment, and recovery of substance use and mental health disorders for young people and their families.

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Appendix A

Selected Definitions of Personal Recovery

This appendix includes selected definitions of personal recovery from the substance abuse perspective as well as from the adult and child/adolescent mental health perspectives. The concept of resilience is also important across substance abuse and mental health. Thus, selected definitions of resilience are included here as well. See Appendix I for the source referred to by the number in parentheses after each definition. Page number is indicated in parentheses for direct quotes.

From the Substance Abuse Perspective

Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life (18, p. 5).

Recovery is the process of pursuing a fulfilling and contributing life, regardless of the difficulties one has faced. It involves not only the restoration but continued enhancement of a positive identity and personally meaningful connections and roles in one's community. Recovery is facilitated by relationships and environments that provide hope, empowerment, choices, and opportunities that promote people reaching their full potential as individuals and community members (44, p. 12).

Recovery is the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life (79, p. 236).

Recovery from substance dependence is a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship (61, p. 222).

[Recovery is] overcoming both physical and psychological dependence to a psychoactive drug while making a commitment to sobriety (6, p. 245).

In our model, the word recovery refers both to internal conditions (the attitudes, experiences, and processes of change of individuals who are recovering) and external conditions (the circumstances, events, policies, and practices that may facilitate recovery). Together, internal and external conditions produce the process called recovery. These conditions have a reciprocal effect, and the process of recovery, once realized, can itself become a factor that further transforms both internal and external conditions (39, p. 482).

We endorse a broad vision of recovery that involves a process of restoring or developing a positive and meaningful sense of identity apart from one's condition and a meaningful sense of belonging while rebuilding a life despite or within the limitations imposed by that condition (40, p. 10).

The current use of the term wellbriety by Native American recovery advocates (17) similarly reflects efforts to define recovery as sobriety plus global health or quality of life (78, p. 234).

Wellness is defined as the movement of a client toward his or her maximum physical or mental health and recovery (26, p. 18).

Recovery connotes the broader resolution of these problems and the movement toward greater physical, emotional, and relational health. Recovery also frequently involves improved educational and vocational performance, the formulation of and movement toward life goals, and acts of service to the community (83, p. 1).

[Long-term recovery is defined] in terms of an enduring lifestyle marked by: 1) the resolution of alcohol and other drug problems, 2) the progressive achievement of global (physical, emotional, relational) health, and 3) citizenship (life meaning and purpose, self-development, social stability, social contribution, elimination of threats to public safety) (61, 79, 45, 78). These broad arenas embrace four of the seven performance domains that are part of SAMHSA's National Outcome Measures: abstinence from drug use and alcohol abuse, finding and keeping a job or enrolling or staying in school, decreased criminal justice system involvement, safe and stable housing, and social connectedness (58, 78, p. 25).

Resilience is the strength individuals and communities attain by reducing risk factors and increasing protective factors (35, p. 11).

From the Adult Mental Health Perspective

Recovery is a process by which people who have a mental illness are able to work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms (50, p. 5).

The Surgeon General's Report on Mental Health described recovery as focusing on the restoration of hope, self-esteem, and identity, and on attaining meaningful roles in society, as contrasted with a focus primarily on symptom relief (71, p. 97).

Recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles (4, p. 101).

Recovery requires that persons with serious mental illnesses remain in control of their own lives, including their own mental health care, until, unless, and only for as long as there are clear and convincing reasons, grounded in law, for their sovereignty to be handed over temporarily to others (20, p. 642).

Recovery is a process in which the person engages to figure out how to manage and live with his or her disorder (20, p. 643).

Recovery is, in part, the process of "recovering" the self by reconceptualizing illness as only a part of the self, not as a definition of the whole. As consumers reconnect with their selves, they begin to experience a sense of self-esteem and self-respect that allows them to confront and overcome the stigma against persons with mental illness that they may have internalized, thus allowing further connection with the self (39, p. 483).

The second healing process is control—that is, finding ways to relieve the symptoms of the illness or reduce the social and psychological effects of stress (39, p. 483).

Resilience: a dynamic process that leads to positive adaptation, even with a context of adversity (46, p. 11).

From the Child/Adolescent Mental Health Perspective

Recovery is best understood as a process that enables the young person and his or her significant adults to understand and manage the realities of an emotional disorder, so that the young person can return to a positive developmental path (37, p. 22).

Resilience—literally, the ability to “bounce back” (27, p. 6).

For individuals, these include good intellectual functioning, easy-going disposition, self-efficacy, high self-esteem, talents, and faith. Within the family, having a close relationship to a caring parent figure, authoritative parenting (characterized by warmth, structure, and high expectations), socioeconomic advantage, and connections to extended family networks have all been shown to be important. Outside of the family, factors associated with resilience include bonds to prosocial adults who can serve as good role models, connections to positive community organizations, and attending effective schools (47, p. 6).

Resilience brings attention to the strengths of the child as protective factors and as assets for the process of positive development. Resilience also draws attention to the family as the most important asset a child can have (31, p. 25).

Appendix B

Recovery-Oriented Systems of Care Defined

The literature provides a number of working definitions of recovery-oriented systems of care that are applicable in the substance abuse and mental health fields. While there are many similar elements in these definitions, it is important to note the differences as well. Selected descriptions of recovery-oriented systems of care are listed below by discipline. See Appendix I for the source referred to by the number in parenthesis after each definition. Page number is indicated in parentheses for direct quotes.

From the Adult Substance Abuse Perspective

Recovery-Oriented Systems of Care (ROSCs) support person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families, and communities to take responsibility for their sustained health, wellness, and recovery from alcohol and drug problems. ROSCs offer a comprehensive menu of services and supports that can be combined and readily adjusted to meet the individual's needs and chosen pathway to recovery. ROSCs encompass and coordinate the operations of multiple systems, providing responsive, outcomes-driven approaches to care. ROSCs require an ongoing process of systems improvement that incorporates the experiences of those in recovery and their family members (42, p. 6).

The phrase recovery-oriented systems of care...refers to the complete network of indigenous and professional services and relationships that can support the long-term recovery of individuals and families, and the creation of values and policies in the larger cultural and policy environment that are supportive of these recovery processes. The "system" in this phrase is not a Federal, State, or local agency, but a macro-level organization of the larger cultural and community environment in which long-term recovery is nested (78, p. 18).

In a recovery-oriented system...all treatment is person centered or driven by individual needs as assessed by a trained and competent practitioner. These individual needs will vary but must always be understood in a culturally relevant manner and viewed as factors that can maximize the opportunity for understanding, acceptance, and active participation of the individual (and family) in his or her wellness and recovery plan. In treating the substance dependence, a continuum of care approach emphasizes the increasing but continuous participation of the individual in her or his care from treatment inception through wellness and recovery. Care, whether prevention, intervention, treatment, or recovery support, is provided within a continuum understanding, at an appropriate level that anticipates related conditions and can prevent potential increases in severity...Both the family and community play key roles in recovery and wellness and must be considered in all aspects of care, both as supports and/or barriers to wellness and recovery (26, p. 8–9).

Recovery management is a chronic care approach to the provision of client-directed management of services and supports for persons with chronic disorders at the provider level that reflects many of the elements of ROSCs. Unlike ROSCs, which are designed to address the full spectrum of needs of individuals with substance use problems and disorders, including screening, brief intervention, brief treatment, and early intervention, recovery management is a clinical approach taken from a chronic disease management approach applied in general medical settings (42, p. 6).

Recovery management...is a philosophy of organizing addiction treatment and recovery support services to enhance prerecovery engagement, recovery initiation, long-term recovery maintenance, and the quality of personal/family life in long-term recovery...Achieving both a recovery-oriented system of care and the implementation of a recovery management philosophy requires substantial changes in treatment philosophies, purchase-of-care strategies, regulatory policies and monitoring protocols, clinical and support service menus, service relationships, the roles of the service professional and service consumer, the training and supervision of staff and volunteers, and intra- and inter-organizational relationships (78, p. 18).

The most dramatic difference between acute-care and recovery management models of addiction treatment is the span of time over which the service relationship is expected to extend. In the acute-care model, the span of involvement is expected to be short and is lengthened only by default, via the repeated relapse and readmission of clients. Treatment providers participate in the illusion of recovery stability by “graduating” clients with prolonged, severe substance use and related problems following short periods of treatment and sobriety. Yet two pervasive themes in long-term follow-up studies are that treatment effects diminish over time and that relapse rates are high (48, 78). This raises the question of how long addiction professionals should remain involved in the lives of their clients. The extended length of involvement advocated within the recovery management model is based on the following principle: health-care professionals should remain involved and available to those they serve until long-term recovery of the condition being treated can be self-managed by the patient, family, and extended support network (78, p. 107–108).

Recovery capital (RC) is an important concept in understanding personal recovery as well as recovery-oriented systems of care. RC is the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from severe alcohol and other drug (AOD) problems (33). Personal RC can be divided into physical and human capital. A client’s physical RC includes physical health; financial assets; health insurance; safe and recovery-conducive shelter; clothing; food; and access to transportation. Human RC includes a client’s values, knowledge, educational/vocational skills and credentials; problem-solving capacities; self-awareness; self-esteem; self-efficacy (self-confidence in managing high-risk situations); hopefulness/optimism; perception of one’s past/present/future; sense of meaning and purpose in life; and interpersonal skills. Family/social RC encompasses intimate relationships; family and kinship relationships (defined here nontraditionally (i.e., family of choice)); and social relationships that are supportive of recovery efforts. Community RC encompasses community attitudes/policies/resources related to addiction and recovery that promote the resolution of AOD problems. Cultural capital is a form of community capital. It constitutes the local availability of culturally prescribed pathways of recovery that resonate with particular individuals and families (82, p. 22–27).

From the Child and Adolescent Mental Health Perspective

A system of care is a coordinated network of community-based services and supports that are organized to meet the challenges of children and youth with serious mental health needs and their families. Families and youth work in partnership with public and private organizations to design mental health services and supports that are effective, that build on the strengths of individuals, and that address each person’s cultural and linguistic needs. A system of care helps children, youth, and families function better at home, in school, in the community, and throughout life (65, p. 4).

A set of values and principles undergird a system of care. In a system of care services are comprehensive and include a broad array; are individualized; provided in the least restrictive, appropriate setting; are coordinated at both the system and service delivery levels; involve youth and families as partners; are culturally and linguistically competent; and emphasize early identification and prevention. Services and supports are provided in different settings; they include clinical interventions, evidence-supported practice, and an array of supports (28, p. 45).

Wraparound approaches are integral to systems of care. Wraparound is a team-based planning process intended to provide individualized, coordinated, family-driven and youth-guided care to meet the complex needs of children and adolescents involved with multiple child- and family-serving systems (e.g., mental health, child welfare, juvenile justice, education), who are at risk of placement in institutional settings, and who experience emotional, behavioral, or mental health difficulties (11, p. 1).

The wraparound process includes four phases: engagement and team preparation, initial plan development, implementation, and transition (74). The plan addresses multiple life domains: family, home (basic needs of food and shelter), emotional and psychological, social and recreational, educational, vocational, safety and crisis, cultural and spiritual, medical, and legal (38, p. 1–3).

A wraparound plan includes services and supports, particularly “natural supports,” available in the family and youth’s network of interpersonal, social, and community relationships. The wraparound process is strengths-based, supporting youth and family to recognize, utilize, and build talents, assets, and positive capacities. Wraparound is a specific method for treatment planning and care coordination. The theory of change provides a rationale for why treatments included in a wraparound plan are likely to be more effective (due to better treatment acceptability, engagement, and agreement about treatment goals) and why participation in the wraparound process may yield more positive outcomes (due to increased optimism, self efficacy, social support, and coping skills) (73, p. 1).

Appendix C Recovery Consultative Session Agenda

Consultative Session

To Design a Recovery-Oriented Care Model for Adolescents and Transition Age Youth With Substance Use Disorders or Co-Occurring Mental Health Disorders

Day One: Thursday, November 13, 2008

WESTAT
1441 W. Montgomery Avenue
Westbrook Building, Room 386
Rockville, Maryland

Time	Agenda Item
8:30 – 9:45 a.m.	<p>Welcome, Purpose, and Goals of Meeting</p> <p><i>Sybil K. Goldman, M.S.W. (Facilitator for Day I)</i> Senior Advisor, Georgetown University National Technical Assistance Center for Children’s Mental Health</p> <p><i>Larke Huang, Ph.D.</i> Senior Advisor on Children Office of the Administrator, SAMHSA</p> <p><i>Randy Muck, M.Ed.</i> Chief, Targeted Populations Branch Division of Services Improvement Center for Substance Abuse Treatment (CSAT), SAMHSA</p> <p><i>Diane Sondheimer, M.S.N, M.P.H, CPNP</i> Deputy Chief, Child, Adolescent ,and Family Branch Center for Mental Health Services (CMHS), SAMHSA</p> <p>Participant Introductions (Name, Organization, and one sentence on why this meeting is important to you)</p>
9:45 – 10:45 a.m.	<p>What Does the Research Tell Us?</p> <p>Presentation of Data from CSAT Grantees <i>Mark D. Godley, Ph.D.</i>, Chestnut Health Systems</p> <p>Presentation of Data from the National Evaluation of CMHS’s Comprehensive Community Mental Health Services for Children and Their Families Program <i>Christine Walrath, Ph.D.</i>, Macro International, Inc.</p> <p>Discussion</p>
10:45 – 11:00 a.m.	Break
11:00 – 11:30 a.m.	<p>Youth and Family Perspectives</p> <p><i>Elise Lopez</i>, Compass Behavioral Health Care</p> <p><i>Shannon CrossBear</i>, National Federation of Families for Children’s Mental Health</p>
11:30 – 12:00 noon	<p>Community Perspectives</p> <p><i>Dennis Noonan, M.S.W., L.C.S.W.</i>, Pima Prevention Partnership</p> <p><i>Angelo Adson</i>, Intercultural Family Services, Inc</p>
12:00 – 12:45 p.m.	Box Lunch (provided in room)

Time	Agenda Item
	<p>Group Discussion Topics for Day 1:</p> <p>Outcomes (Topic 1): <i>Outcomes We Want to Achieve for Young People With Substance Use or Co-Occurring Mental Health Disorders, Their Families, and Their Communities</i></p> <p>Values and Principles (Topic 2): <i>Identifying Values and Principles for a Recovery-Oriented System of Care</i></p>
12:45 – 1:00 p.m.	<p>Charge to the Group</p> <p>Main conference room (386)</p>
1:00 – 3:00 p.m.	<p>Break Out Into Groups</p> <p>Conference Center Building (Rooms RW2521c, RW3500c, and RW4500c)</p>
3:00 – 3:15 p.m.	<p>Break</p>
3:15 – 4:00 p.m.	<p>Report Back – Main Conference Room (386)</p>
4:00 – 5:00 p.m.	<p>Discussion: Consensus, Challenges, Opportunities, Recommendations</p>
5:00 – 5:15 p.m.	<p>Review of Day’s Work</p> <p>“Parking Lot” Issues to Address</p> <p>Plan for Day Two</p>

Day Two: Friday, November 14, 2008

SAMHSA
 One Choke Cherry Road
 Seneca Conference Room
 Rockville, Maryland

Time	Agenda Item
8:45 – 9:00 a.m.	<p>Opening Remarks</p> <p><i>Doreen Cavanaugh, Ph.D.</i> (Facilitator for Day II), Research Associate Professor, Georgetown University Health Policy Institute</p> <p><i>A. Kathryn Power, M.Ed.</i>, Director, Center for Mental Health Services, SAMHSA</p>
9:00 – 10:00 a.m.	<p>Presentations on System, Service, and Support Issues: Lessons Learned</p> <p><i>Beth Dague, M.A.</i>, Cuyahoga Tapestry Systems of Care</p> <p><i>Patrick Kanary, M.Ed.</i>, Center for Innovative Practices, Institute for the Study of Prevention of Violence, Kent State University</p> <p><i>Calvin Trent, Ph.D.</i>, City of Detroit, Department of Health and Wellness Promotion</p>
	<p>Group Discussion Topics for Day 2:</p> <p>Services and Supports (Topic 3): <i>Identifying Services and Supports in a Recovery-Oriented System of Care</i></p> <p>Infrastructure (Topic 4): <i>Identifying Infrastructure Elements Needed for a Recovery-Oriented System of Care</i></p>
10:00 – 10:15 a.m.	<p>Charge to the Group</p> <p>Seneca Conference Room</p>
10:15 a.m. – 12:15 p.m.	<p>Break Out Into Groups</p> <p>Rooms Seneca, 8-1049, 8-1082, and VTC L-1057</p>
12:15 – 1:00 p.m.	<p>Lunch and Presentation:</p> <p>CSAT Perspective on Recovery-Oriented Systems of Care for Youth</p> <p><i>H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM</i>, Director, Center for Substance Abuse Treatment, SAMHSA</p>
1:00 – 1:45 p.m.	<p>Report Back</p>
1:45 – 2:00 p.m.	<p>Break</p>
2:00 – 3:00 p.m.	<p>Discussion: Consensus, Challenges, Opportunities, Recommendations</p>
3:00 – 3:30 p.m.	<p>Next Steps and Wrap-Up</p>

Appendix D

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Appendix E

Recovery Consultative Session Discussion Questions

Discussion Session Questions Day 1

Topic I: Outcomes

- What outcomes for young people, families, and communities do we want to achieve within a recovery-oriented system of care? Indicate the top five priorities.

Topic II: Values and Principles

- Which values are essential for a recovery-oriented system of care for youth? Indicate the top five priorities.
- Which principles are essential for a recovery-oriented system of care for youth? Indicate the top five priorities.

Discussion Questions

- What are the challenges to achieving these outcomes and implementing these values and principles?
- What opportunities/resources exist?
- What are your overall recommendations?
- Prepare for presentation of group ideas.

Discussion Session Questions Day 2

Topic III: Services and Supports

- Which services are appropriate and necessary for a recovery-oriented system of care for youth? Indicate the top five priorities.
- Which supports are appropriate and necessary for a recovery-oriented system of care for youth? Indicate the top five priorities.

Topic IV: Infrastructure

- Which system infrastructure elements are essential for a recovery-oriented system of care? Indicate the top five priorities.

Discussion Questions

- What are the challenges for developing/providing necessary services and supports and for building necessary infrastructure?
- What opportunities/resources exist?
- What are your overall recommendations?
- Prepare for presentation of group ideas.

Appendix F

Elements of a Recovery-Oriented System of Care Identified by Discussion Group Participants or in the Literature

Values and Principles

Note: In the following list, items selected by two or more discussion groups are designated by superscript 1. Items chosen by one discussion group are identified by superscript 2. Items identified through the literature review and supported by the groups but not prioritized by any discussion groups are identified by superscript 3.

In general, the members in each of the four consultative session discussion groups agreed with all of the values and principles listed in Tables 1 and 2 of the recovery consultative session resource materials (see Appendix H). Participants recommended combining values and principles for this report and identified them as:

1. Being family focused

- Family involvement¹
- Family-focused treatment¹
- Family driven¹
- Broad definition of family¹
- Empowering parents²
- Family voice³

2. Being age appropriate

- Age appropriate¹
- Normal social roles²
- Secure bases³
- Future orientation³
- Long-term perspective³

3. Reflecting the developmental stages of youth

- Developmental approach¹

4. Acknowledging the nonlinear nature of recovery

- Nonlinear nature of recovery¹
- Addresses relapse²
- Transformative³
- New nomenclature³
- Incorporating illness³
- Employs a chronic disorder management approach³
- Encompasses all phases of care³

Values and Principles (cont.)

Note: In the following list, items selected by two or more discussion groups are designated by superscript 1. Items chosen by one discussion group are identified by superscript 2. Items identified through the literature review and supported by the groups but not prioritized by any discussion groups are identified by superscript 3.

5. Promoting resilience

- Promoting resilience¹
- Optimism³
- Learning from successes/mistakes³
- Redefining self³
- Persistence³
- Personal vision³
- Opportunity³
- Wellness focus³
- Opportunity to take risks to fail³
- Providing social opportunities³
- Self-esteem/self-worth³
- Positive youth development focus³

6. Being strengths based

- Strengths-based¹
- Positive reinforcement³

7. Identifying recovery capital

- Addresses recovery capital¹

8. Supporting youth empowerment

- Empowering²
- Person/client centered³
- Self-directed³
- Client participation at all levels³
- Consumer-driven plan of care³
- Consumer autonomy/independence³
- Youth involvement³
- Partnership consultant relationship³
- Commitment to peer support and consumer-operated services³
- Financial support for consumer participation³

9. Being youth guided

- Youth guided²

10. Being individualized

- Individualized²
- Single wraparound plan³
- Gender appropriate³

11. Promoting hope

- Hope²

Values and Principles (cont.)

Note: In the following list, items selected by two or more discussion groups are designated by superscript 1. Items chosen by one discussion group are identified by superscript 2. Items identified through the literature review and supported by the groups but not prioritized by any discussion groups are identified by superscript 3.

12. Emphasizing accessibility

- Accessible²
- Multiple pathways²
- No wrong door³
- Entry at any time³
- Assures speedy reentry into treatment³
- Outreach³

13. Providing choice

- Provider competition²
- Providing choice³

14. Containing a broad array of services and supports

- Menu of services²
- Broad array of services and supports³
- Community based³
- Least restrictive setting³
- Supportive environment³
- Peer-run programs³
- Comprehensive³
- Supports individual to rebuild life in community³
- Early identification³

15. Being culturally competent

- Responsiveness to cultural belief systems²
- Culturally competent³
- Respecting spiritual, religious, and secular beliefs³

16. Promoting individual responsibility

- Responsibility²
- Provides structure/rules³

17. Being integrated

- Integrated services²
- Coordinated³

18. Using an ecological approach

- Ecological system perspective²
- Holistic³

Values and Principles (cont.)

Note: In the following list, items selected by two or more discussion groups are designated by superscript 1. Items chosen by one discussion group are identified by superscript 2. Items identified through the literature review and supported by the groups but not prioritized by any discussion groups are identified by superscript 3.

19. Providing continuity of care

- Continuous²
- Service duration³
- Long-term recovery focus³
- Continuous support³
- Continuing care³
- Follow-up³

20. Engaging youth

- Engaging²

21. Being nondiscriminatory

- Nondiscriminatory²
- Equal opportunity for wellness³

22. Being collaborative

- Collaborative²
- Collective fiscal responsibility³

23. Being cost-effective

- Cost-effective²

24. Promoting authenticity

- Honesty²
- Integrity²
- Fun²
- Respect²
- Trust²
- Tolerance²
- Patience²

25. Protecting consumer rights

- Consumer rights³

26. Being evidence based

- Evidence based³

27. Improving quality of life

- Improving quality of life³

28. Being flexible/adaptable to client need

- Flexibility³
- Accept client as s/he is³
- Flexibly financed³
- Adaptable to client need³

Values and Principles (cont.)

Note: In the following list, items selected by two or more discussion groups are designated by superscript 1. Items chosen by one discussion group are identified by superscript 2. Items identified through the literature review and supported by the groups but not prioritized by any discussion groups are identified by superscript 3.

29. Promoting accountability

- Outcomes driven³

30. Being realistic

- Rooted in reality³

31. Being statewide

- Statewide³

Services and Supports

Note: In the following list, items selected by two or more discussion groups are designated by superscript 1. Items chosen by one discussion group are identified by superscript 2. Items identified through the literature review and supported by the groups but not prioritized by any discussion groups are identified by superscript 3.

Discussion group members agreed that all of the services and supports listed in Tables 3 and 4 of the recovery consultative session resource materials were important (see Appendix H). Participants stressed that a recovery-oriented system must provide a comprehensive array of formal and informal services and supports that are individualized and flexible. Participants recommended combining services and supports for this report and identified them as:

1. Ensuring ongoing family involvement

- Family/parent support¹
- Family/parent counseling¹
- Family team¹
- Family preservation²
- Sibling services²
- Family/marriage education³
- Parent aides³

2. Providing linkage to services

- Continuing care with contacts¹
- Care management; link to services/supports¹
- Multiagency teams¹
- Certified family navigator advocacy/support network²
- Post-treatment monitoring³
- Post-treatment support³

Services and Supports (cont.)

Note: In the following list, items selected by two or more discussion groups are designated by superscript 1. Items chosen by one discussion group are identified by superscript 2. Items identified through the literature review and supported by the groups but not prioritized by any discussion groups are identified by superscript 3.

3. Assuring that the range of services and supports address multiple domains in a young person's life

- Life skills training¹
- Vocational training and assistance¹
- Recreational opportunities¹
- Transitions planning¹
- Social support¹
- Housing assistance and services¹
- Leadership development¹
- Recovery high school/college¹
- Afterschool services²
- Professionally supervised recovery college dorm²
- Funding for basic needs²
- Comprehensive student assistance programs²
- Art-related activities and public arenas to highlight creativity (art, music, dance, spiritual/faith-based)²
- Faith-based community support groups²
- Education and training³
- Skill development³
- Substance abuse education³
- Supported community living³
- Independent living³
- Specialized educational services³
- Community services activities³
- Vocational training, career development, employment support³
- Jobs³
- Household management³
- Tutors³

4. Fostering social connectedness

- Mentors¹
- Aftercare groups³
- Self-help support groups³
- Opportunities for community service integration³
- Secular organizations for sobriety³
- Women in sobriety³
- Service projects³
- Living with others in recovery³
- Volunteers³
- Local recovery celebration events³
- Mutual aid support groups³

Services and Supports (cont.)

Note: In the following list, items selected by two or more discussion groups are designated by superscript 1. Items chosen by one discussion group are identified by superscript 2. Items identified through the literature review and supported by the groups but not prioritized by any discussion groups are identified by superscript 3.

5. Providing specialized recovery supports

- Internet based support tools¹
- Recovery coach/consultant²
- Recovery groups²
- Recovery checkups³
- Outreach³
- Recovery home³
- Telephone contact³
- Interactive voice response systems³
- Voucher-based incentives³
- Peer leader, guide, escort³
- Recovery support specialists³
- Sponsors³
- Job coach³

6. Providing therapeutic/clinical interventions

- Therapy and clinical interventions¹
- Crisis management stabilization²
- Relapse prevention³
- Evidence-based practices³
- Strengths-based assessment³
- Screening³
- Emotional/anger management³
- Mental health counseling³
- Motivational interviewing³
- Behavioral aides³
- Residential treatment³
- Inpatient treatment³
- Therapeutic foster care³
- Therapeutic group homes³

7. Providing ancillary supports

- Legal advocacy²
- Transportation³
- Child care³

Infrastructure

Note: In the following list, items selected by two or more discussion groups are designated by superscript 1. Items chosen by one discussion group are identified by superscript 2. Items identified through the literature review and supported by the groups but not prioritized by any discussion groups are identified by superscript 3.

Discussion group members agreed with the need for all of the infrastructure elements listed in Table 5 of the recovery consultative session resource materials (see Appendix G). The participants recommended that the infrastructure underlying a recovery-oriented system of care should assure:

1. Family involvement at the design/policy level

- Family/family/parent advocacy and partnership/equal partnership¹
- Youth and families in decision-making/policy-making roles (leaders in recovery—boards, decision-makers)²
- Infrastructure support for youth and family involvement²

2. Policy change at the Federal, State, and provider levels

- State advisory/policy body to make recommendations¹
- Recovery representation at policy and clinical decision making³

3. Collaborative financing

- Blended and braided funding¹
- Performance-based contracting²
- Purchasing strategies, including recovery support services (stipend, peer mentoring, family navigator)²
- Joint purchasing³
- Adequate capitalization³
- Funding diversification³
- Money must follow the person³
- Continuity of funding (availability of funding streams that assure sustained support)³
- Development of a recovery-oriented philosophy of financing³
 - No outcomes, no income (person-centered care)³
 - Persons select provider (freedom of choice)³
 - Protection from undue influence (freedom of choice)³
 - Providers don't oversee themselves (monitoring)³
 - Providers compete for business (performance-based contracting)³

4. Collaboration and integration across all youth-serving systems

- Community integration/communities of support¹
- Institutional relationships with local communities (with particular emphasis on communities of recovery)¹

Infrastructure (cont.)

Note: In the following list, items selected by two or more discussion groups are designated by superscript 1. Items chosen by one discussion group are identified by superscript 2. Items identified through the literature review and supported by the groups but not prioritized by any discussion groups are identified by superscript 3.

5. Workforce development

- Competencies¹
- Curriculum development²
- Licensing²
- Recruitment²
- Retention²
- Equitable salaries²
- Supervision and clinical oversight²
- Evidence-Based Practices²
- Workforce stability³
- Safety protocols for service providers and consumers³
- Knowledge adoption³
- Training³

6. Leadership

- Committed to principles of recovery and youth¹
- Leaders in recovery—boards, decision-makers, etc. (youth and family involved)²
- Strong administrative and clinical leadership³

7. Accountability

- Quality assurance and performance measurement/monitoring for all providers including nontraditional providers¹
- Continuous quality improvement (CQI)¹
- Evaluation of complex adaptive system²

8. Systems management

- Planning²
- Technology (application, capability)²
- Provider network³
- Stability of provider organizational ownership³
- Communication³
- Contracting³
- Interagency supervision/oversight³
- Governance³
- Recovery-focused organizational culture³

Infrastructure (cont.)

Note: In the following list, items selected by two or more discussion groups are designated by superscript 1. Items chosen by one discussion group are identified by superscript 2. Items identified through the literature review and supported by the groups but not prioritized by any discussion groups are identified by superscript 3.

9. Utilization management

- Clinical decision-making³
 - Supervision³
- Clinical algorithms/decision support³

Outcomes

Note: In the following list, items selected by two or more discussion groups are designated by superscript 1. Items chosen by one discussion group are identified by superscript 2. Items identified through the literature review and supported by the groups but not prioritized by any discussion groups are identified by superscript 3.

Consultative session participants reviewed the National Outcomes Measures (NOMs) endorsed by SAMHSA. Discussion group members stressed that a recovery-oriented system of care should include outcomes for the individual young person, the family, and the system. Individuals should be viewed in the context of their families. Family representatives said that families want certain outcomes for their children, including youth being at home, getting along with family, having friends, being happy, and living in safe neighborhoods. Systems need to be holistic in meeting the needs of youth and families and must function in ways that support positive family and youth outcomes. Concepts of youth thriving, even with substance abuse and mental health problems, and how to measure the elements of thriving were important to group members. In general, the group endorsed the CSAT working assumption on abstinence, stressing that a recovery-oriented system of care should allow for episodes of relapse. Relapse should not be viewed as a failure, but rather as a part of the recovery process. Participants recommended that outcomes for a recovery-oriented system of care should focus on:

1. Individual

- Social connectedness¹
- Reciprocity: increased capacity of youth to give back to the community¹
- Increased self-sufficiency¹
- Increased number of developmentally appropriate assets¹
- Days of abstinence²
- Daily abstinence²
- Reduced use of substances²
- Reduced risky behaviors²
- Increased quality of life²
- Increased personal capacity²
- Increased recovery capital²
- Prosocial behaviors²
- Improved school attendance/completion of education²

2. Family

- Outcomes for families:
 - Success for families in recovery (supportive of family and sibling recovery/families able to recover)¹
 - Positive peer/family interactions²
- Individuals need to be seen in context of families. Systems need to address families in a holistic way.³

Outcomes (cont.)

Note: In the following list, items selected by two or more discussion groups are designated by superscript 1. Items chosen by one discussion group are identified by superscript 2. Items identified through the literature review and supported by the groups but not prioritized by any discussion groups are identified by superscript 3.

3. Systems*

- Provide easy access into the service system with multiple points of entry¹
- Are supportive of success for families in recovery/family-focused, recovery-oriented services and supports to enable adults to be supportive of youth in recovery¹
- Provide opportunities for youth to give back (includes youth to youth)¹
- Meet basic needs²
- Are integrated²
- Align policies²
- Reduce stigma²
- Enable communities to respect and support recovery²

* Note: Some of these system “outcomes” are concepts or goals for how the system should function and may be difficult to measure as an outcome.

Appendix G Comparison Tables

The following tables compare the priorities identified by the consultative session participants with the weighted findings from the literature review. Tables highlight both areas of agreement and divergence. Letters A through D refer to the four consultative session groups. Elements identified by one or more consultative session group but not identified through the literature review are italicized. See Appendix I for the source referred to by the number(s) in the literature citations.

Recovery Values and Principles Comparison Tables

Note: In the following tables, “Total” indicates the unduplicated count of group endorsements or literature citations. Under “Literature Citations,” the number in parenthesis refers to the total number of times the item appears in the reviewed literature. The following numbers refer to the numbered sources in the bibliography for the recovery consultative session briefing materials (see Appendix I).

A recovery-oriented system of care should include these values and principles:

Being family-focused

Element	Group Endorsements	Element	Literature Citations
Family involvement	(2) A; D	Family involvement	(5) 18, 27, 29, 66, 67
Family-focused treatment	(2) B; D	Family-focused treatment	(1) 78
Family driven	(2) B; C	Family driven	(1) 50
<i>Broad definition of family</i>	(2) C; D	<i>Broad definition of family</i>	(0)
Empowering parents	(1) D	Empowering parents	(1) 53
Family voice	(0)	Family voice	(5) 18, 28, 53, 64, 73
Total	(4) A; B; C; D	Total	(11) 18, 27, 28, 29, 50, 53, 64, 66, 67, 73, 78

Being age appropriate

Element	Group Endorsements	Element	Literature Citations
Age appropriate	(3) A; C; D	Age appropriate	(1) 42
Normal social roles	(1) D	Normal social roles	(3) 19, 21, 29
Secure bases	(0)	Secure bases	(3) 20, 21, 22
Future orientation	(0)	Future orientation	(2) 27, 28
Long-term perspective	(0)	Long-term perspective	(1) 29
Positive youth development focus	(0)	Positive youth development focus	(1) 28
Total	(3) A; C; D	Total	(9) 19, 20, 21, 22, 27, 28, 29, 36, 42

Reflecting the developmental stages of youth

Element	Group Endorsements	Element	Literature Citations
Developmental approach	(3) A; C; D	Developmental approach	(1) 36
Total	(3) A; C; D	Total	(1) 36

Recovery Values and Principles Comparison Tables (cont.)

Note: In the following tables, “Total” indicates the unduplicated count of group endorsements or literature citations. Under “Literature Citations,” the number in parenthesis refers to the total number of times the item appears in the reviewed literature. The following numbers refer to the numbered sources in the bibliography for the recovery consultative session briefing materials (see Appendix I).

Acknowledging the nonlinear nature of recovery

Element	Group Endorsements	Element	Literature Citations
Nonlinear nature of recovery	(2) B; D	Nonlinear nature of recovery	(6) 16, 18, 27, 28, 29, 36
Addresses relapse	(1) D	Addresses relapse	(4) 5, 18, 28, 36
Transformative	(0)	Transformative	(1) 36
New nomenclature	(0)	New nomenclature	(2) 21, 53
Incorporating illness	(0)	Incorporating illness	(1) 19
Employs chronic disorder management approach	(0)	Employs chronic disorder management approach	(1) 18
Encompasses all phases of care	(0)	Encompasses all phases of care	(1) 21
Total	(2) B; D	Total	(10) 5, 16, 18, 19, 21, 27, 28, 29, 36, 53

Promoting resilience

Element	Group Endorsements	Element	Literature Citations
Promoting resilience	(2) A; B	Promoting resilience	(6) 18, 19, 28, 51, 81, 83
Optimism	(0)	Optimism	(4) 10, 27, 28, 75
Learning from success/mistake	(0)	Learning from success/mistake	(2) 21, 22
Redefining self	(0)	Redefining self	(1) 19
Persistence	(0)	Persistence	(1) 11
Personal vision	(0)	Personal vision	(1) 74
Opportunity	(0)	Opportunity	(1) 77
Wellness focus	(0)	Wellness focus	(1) 18
Opportunity to take risks/to fail	(0)	Opportunity to take risks/to fail	(3) 20, 21, 22
Providing social opportunities	(0)	Providing social opportunities	(3) 10, 18, 38
Self-esteem/self-worth	(0)	Self-esteem/self-worth	(2) 18, 68
Total	(2) A; B	Total	(17) 10, 11, 18, 19, 20, 21, 22, 27, 28, 38, 51, 68, 74, 75, 77, 81, 83

Being strengths based

Element	Group Endorsements	Element	Literature Citations
Strengths based	(2) A; C	Strengths based	(10) 10, 11, 16, 18, 21, 27, 29, 66, 73, 74
Positive reinforcement	(0)	Positive reinforcement	(1) 18
Total	(2) A; C	Total	(10) 10, 11, 16, 18, 21, 27, 29, 66, 73, 74

Recovery Values and Principles Comparison Tables (cont.)

Note: In the following tables, “Total” indicates the unduplicated count of group endorsements or literature citations. Under “Literature Citations,” the number in parenthesis refers to the total number of times the item appears in the reviewed literature. The following numbers refer to the numbered sources in the bibliography for the recovery consultative session briefing materials (see Appendix I).

Identifying recovery capital

Element	Group Endorsements	Element	Literature Citations
Addresses recovery capital	(2) B; D	Addresses recovery capital	(3) 33, 78, 82
Total	(2) B; D	Total	(3) 33, 78, 82

Empowering youth/consumer

Element	Group Endorsements	Element	Literature Citations
Empowering	(1) A	Empowering	(7) 10, 16, 18, 19, 27, 36, 54
Person/client centered	(0)	Person/client centered	(7) 10, 16, 18, 21, 26, 27, 66
Self-directed	(0)	Self-directed	(7) 10, 16, 18, 21, 26, 28, 60
Client participation at all levels	(0)	Client participation at all levels	(4) 18, 21, 26, 28
Consumer-driven plan of care	(0)	Consumer-driven plan of care	(1) 64
Consumer autonomy/independence	(0)	Consumer autonomy/independence	(2) 18, 77
Youth involvement	(0)	Youth involvement	(1) 53
Partnership consultant relationship	(0)	Partnership consultant relationship	(2) 10, 18
Commitment to peer support and consumer-operated services	(0)	Commitment to peer support and consumer-operated services	(1) 21
Financial support for consumer participation	(0)	Financial support for consumer participation	(1) 21
Total	(2) A; B	Total	(16) 10, 16, 18, 19, 21, 26, 27, 28, 36, 50, 53, 54, 60, 64, 66, 77

Recovery Values and Principles Comparison Tables (cont.)

Note: In the following tables, “Total” indicates the unduplicated count of group endorsements or literature citations. Under “Literature Citations,” the number in parenthesis refers to the total number of times the item appears in the reviewed literature. The following numbers refer to the numbered sources in the bibliography for the recovery consultative session briefing materials (see Appendix I).

Being youth guided

Element	Group Endorsements	Element	Literature Citations
Youth guided	(1) B	Youth guided	(1) 50
Total	(1) B	Total	(1) 50

Being individualized

Element	Group Endorsements	Element	Literature Citations
Individualized	(1) C	Individualized	(12) 5, 10, 11, 16, 18, 21, 26, 27, 36, 64, 66, 84
Single wraparound plan	(0)	Single wraparound plan	(3) 11, 53, 72
Gender appropriate	(0)	Gender appropriate	(1) 42
Total	(1) C	Total	(15) 5, 10, 11, 16, 18, 21, 26, 27, 36, 42, 53, 64, 66, 72, 84

Promoting hope

Element	Group Endorsements	Element	Literature Citations
Hope	(1) A	Hope	(12) 5, 10, 16, 18, 21, 27, 28, 36, 51, 52, 63, 75
Total	(1) A	Total	(12) 5, 10, 16, 18, 21, 27, 28, 36, 51, 52, 63, 75

Emphasizing accessibility

Element	Group Endorsements	Element	Literature Citations
Accessible	(1) A	Accessible	(7) 19, 21, 42, 53, 64, 78, 84
Multiple pathways	(1) A	Multiple pathways	(3) 11, 18, 36
No wrong door	(0)	No wrong door	(5) 18, 19, 21, 53, 64
Entry at any time	(0)	Entry at any time	(1) 21
Assures speedy reentry into treatment	(0)	Assures speedy reentry into treatment	(2) 21, 78
Outreach	(0)	Outreach	(1) 18
Total	(1) A	Total	(10) 11, 18, 19, 21, 36, 42, 53, 64, 78, 84

Recovery Values and Principles Comparison Tables (cont.)

Note: In the following tables, “Total” indicates the unduplicated count of group endorsements or literature citations. Under “Literature Citations,” the number in parenthesis refers to the total number of times the item appears in the reviewed literature. The following numbers refer to the numbered sources in the bibliography for the recovery consultative session briefing materials (see Appendix I).

Providing choice

Element	Group Endorsements	Element	Literature Citations
Provider competition	(1) C	Provider competition	(2) 21, 72
Providing choice	(0)	Providing choice	(9) 5, 11, 18, 19, 21, 28, 29, 36, 60
Total	(1) C	Total	(10) 5, 11, 18, 19, 21, 28, 29, 36, 60, 72

Containing a broad array of services and supports

Element	Group Endorsements	Element	Literature Citations
Menu of services	(1) A	Menu of services	(1) 18
Broad array of services and supports	(0)	Broad array of services and supports	(3) 18, 26, 64
Array of services	(0)	Array of services	(1) 18
Community based		Community based	(8) 10, 11, 18, 27, 42, 53, 66, 78
Least restrictive setting	(0)	Least restrictive setting	(1) 11
Supportive environment	(0)	Supportive environment	(1) 18
Peer-run programs	(0)	Peer-run programs	(4) 18, 27, 43, 78
Comprehensive	(0)	Comprehensive	(4) 18, 27, 28, 66
Supports individual to rebuild life in community	(0)	Supports individual to rebuild life in community	(2) 18, 78
Early identification	(0)	Early identification	(1) 64
Total	(1) A	Total	(12) 10, 11, 18, 26, 27, 28, 42, 43, 53, 64, 66, 78

Being culturally competent

Element	Group Endorsements	Element	Literature Citations
Responsiveness to cultural belief systems	(1) A	Responsiveness to cultural belief systems	(3) 18, 21, 78
Culturally competent	(0)	Culturally competent	(7) 11, 18, 21, 27, 28, 50, 66
Respecting spiritual, religious, and secular beliefs	(0)	Respecting spiritual, religious, and secular beliefs	(5) 18, 36, 38, 77, 78
Total	(1) A	Total	(11) 11, 18, 21, 27, 28, 36, 38, 50, 66, 77, 78

Recovery Values and Principles Comparison Tables (cont.)

Note: In the following tables, “Total” indicates the unduplicated count of group endorsements or literature citations. Under “Literature Citations,” the number in parenthesis refers to the total number of times the item appears in the reviewed literature. The following numbers refer to the numbered sources in the bibliography for the recovery consultative session briefing materials (see Appendix I).

Promoting individual responsibility

Element	Group Endorsements	Element	Literature Citations
Responsibility	(1) A	Responsibility	(7) 16, 19, 20, 26, 27, 28, 84
Provides structure/rules	(0)	Provides structure/rules	(2) 18, 77
Total	(1) A	Total	(9) 16, 18, 19, 20, 26, 27, 28, 77, 84

Being integrated

Element	Group Endorsements	Element	Literature Citations
Integrated services	(1) A	Integrated services	(2) 10, 18
Coordinated	(0)	Coordinated	(8) 11, 18, 26, 27, 53, 64, 66, 78
Total	(1) A	Total	(9) 10, 11, 18, 26, 27, 53, 64, 66, 78

Using an ecological approach

Element	Group Endorsements	Element	Literature Citations
Ecological system perspective	(1) D	Ecological system perspective	(2) 29, 36
Holistic	(0)	Holistic	(5) 10, 16, 18, 27, 36
Total	(1) D	Total	(6) 10, 16, 18, 27, 29, 36

Providing continuity of care

Element	Group Endorsements	Element	Literature Citations
Continuous	(1) D	Continuous	(3) 10, 18, 26
Service duration	(0)	Service duration	(1) 78
Long-term recovery focus	(0)	Long-term recovery focus	(3) 10, 18, 64
Continuous support	(0)	Continuous support	(1) 72
Continuing care	(0)	Continuing care	(1) 18
Follow-up	(0)	Follow-up	(1) 64
Total	(1) D	Total	(6) 10, 18, 26, 64, 72, 78

Recovery Values and Principles Comparison Tables (cont.)

Note: In the following tables, “Total” indicates the unduplicated count of group endorsements or literature citations. Under “Literature Citations,” the number in parenthesis refers to the total number of times the item appears in the reviewed literature. The following numbers refer to the numbered sources in the bibliography for the recovery consultative session briefing materials (see Appendix I).

Engaging youth

Element	Group Endorsements	Element	Literature Citations
Engaging	(1) D	Engaging	(6) 10, 18, 42, 67, 78, 84
Total	(1) D	Total	(6) 10, 18, 42, 67, 78, 84

Being non-discriminatory

Element	Group Endorsements	Element	Literature Citations
Nondiscriminatory	(1) D	Nondiscriminatory	(4) 10, 18, 21, 27
Equal opportunity for wellness	(0)	Equal opportunity for wellness	(2) 18, 21
Total	(1) D	Total	(5) 10, 18, 20, 21, 27

Being collaborative

Element	Group Endorsements	Element	Literature Citations
Collaborative	(1) A	Collaborative	(1) 18
Collective fiscal responsibility	(0)	Collective fiscal responsibility	(4) 18, 26, 53, 72
Total	(1) A	Total	(4) 18, 26, 53, 72

Being cost-effective

Element	Group Endorsements	Element	Literature Citations
<i>Cost-effective</i>	(1) D	<i>Cost-effective</i>	(0)
Total	(1) D	Total	(0)

Promoting authenticity

Element	Group Endorsements	Element	Literature Citations
<i>Honesty</i>	(1) C	<i>Honesty</i>	(0)
<i>Integrity</i>	(1) C	<i>Integrity</i>	(0)
<i>Fun</i>	(1) C	<i>Fun</i>	(0)
<i>Respect</i>	(1) C	<i>Respect</i>	(0)
<i>Trust</i>	(1) C	<i>Trust</i>	(0)
<i>Tolerance</i>	(1) C	<i>Tolerance</i>	(0)
<i>Patience</i>	(1) C	<i>Patience</i>	(0)
Total	(1) C	Total	(0)

Recovery Values and Principles Comparison Tables (cont.)

Note: In the following tables, “Total” indicates the unduplicated count of group endorsements or literature citations. Under “Literature Citations,” the number in parenthesis refers to the total number of times the item appears in the reviewed literature. The following numbers refer to the numbered sources in the bibliography for the recovery consultative session briefing materials (see Appendix I).

Protecting consumer rights

Element	Group Endorsements	Element	Literature Citations
Consumer rights	(0)	Consumer rights	(2) 20, 21
Total	(0)	Total	(5) 20, 21

Being evidence based

Element	Group Endorsements	Element	Literature Citations
Evidence based	(0)	Evidence based	(3) 10, 18, 26
Total	(0)	Total	(3) 10, 18, 26

Improving quality of life

Element	Group Endorsements	Element	Literature Citations
Improving quality of life	(0)	Improving quality of life	(2) 3, 27
Total	(0)	Total	(2) 3, 27

Being flexible/adaptable to client need

Element	Group Endorsements	Element	Literature Citations
Flexibility	(0)	Flexibility	(2) 11, 18
Accept client as s/he is	(0)	Accept client as s/he is	(1) 18
Flexibly financed	(0)	Flexibly financed	(1) 18
Adaptable to client need	(0)	Adaptable to client need	(1) 18
Total	(0)	Total	(2) 11, 18

Promoting accountability

Element	Group Endorsements	Element	Literature Citations
Outcomes driven	(0)	Outcomes driven	(2) 11, 18
Total	(0)	Total	(2) 11, 18

Being realistic

Element	Group Endorsements	Element	Literature Citations
Rooted in reality	(0)	Rooted in reality	(1) 18
Total	(0)	Total	(1) 18

Recovery Values and Principles Comparison Tables (cont.)

Note: In the following tables, “Total” indicates the unduplicated count of group endorsements or literature citations. Under “Literature Citations,” the number in parenthesis refers to the total number of times the item appears in the reviewed literature. The following numbers refer to the numbered sources in the bibliography for the recovery consultative session briefing materials (see Appendix I).

Being statewide

Element	Group Endorsements	Element	Literature Citations
Statewide	(0)	Statewide	(1) 21
Total	(0)	Total	(1) 21

Recovery Services and Supports Comparison Tables

Note: In the following tables, “Total” indicates the unduplicated count of group endorsements or literature citations. Under “Literature Citations,” the number in parenthesis refers to the total number of times the item appears in the reviewed literature. The following numbers refer to the numbered sources in the bibliography for the recovery consultative session briefing materials (see Appendix I).

A recovery-oriented system of care should include these values and principles:

Ensuring ongoing family involvement

Element	Group Endorsements	Element	Literature Citations
Family/parent support	(4) A; B; C; D	Family/parent support	(5) 10, 14, 18, 53, 64
Family/parent counseling	(3) A; B; D	Family/parent counseling	(1) 32
Family team	(2) A; B	Family team	(1) 64
<i>Family preservation</i>	(1) A	<i>Family preservation</i>	(0)
<i>Sibling services</i>	(1) B	<i>Sibling services</i>	(0)
Family/marriage education	(0)	Family/marriage education	(1) 42
Parent aides	(0)	Parent aides	(1) 41
Total	(4) A; B; C; D	Total	(8) 10, 14, 18, 32, 41, 42, 53, 64

Providing linkage to services

Element	Group Endorsements	Element	Literature Citations
Continuing care with contacts	(3) A; B; D	Continuing care with contacts	(4) 18, 30, 32, 78
Case management; link to services/supports	(2) A; B	Case management; link to services/supports	(8) 11, 18, 30, 32, 41, 42, 64, 78
Multiagency teams	(2) A; B	Multiagency teams	(1) 78
<i>Certified family navigator advocacy/support groups</i>	(1) C	<i>Certified family navigator advocacy/support groups</i>	(0)
Post-treatment monitoring	(0)	Post-treatment monitoring	(2) 10, 78
Post-treatment support	(0)	Post-treatment support	(2) 10, 78
Total	(4) A; B; C; D	Total	(9) 10, 11, 18, 30, 32, 41, 42, 64, 78

Recovery Services and Supports Comparison Tables (cont.)

Note: In the following tables, “Total” indicates the unduplicated count of group endorsements or literature citations. Under “Literature Citations,” the number in parenthesis refers to the total number of times the item appears in the reviewed literature. The following numbers refer to the numbered sources in the bibliography for the recovery consultative session briefing materials (see Appendix I).

Assuring that the range of services and supports address multiple domains in a young person’s life

Element	Group Endorsements	Element	Literature Citations
Life skills training	(3) A; B; D	Life skills training	(1) 42
Vocational training and assistance	(3) A; B; D	Vocational training and assistance	(1) 78
Recreational opportunities	(3) B; C; D	Recreational opportunities	(3) 25, 30, 32
Transitions planning	(3) A; B; D	Transitions planning	(2) 18, 41
Social support	(3) A; B; D	Social support	(3) 15, 32, 76
Housing assistance and services	(2) B; D	Housing assistance and services	(2) 41, 42
<i>Leadership development</i>	(2) C; D	<i>Leadership development</i>	(0)
<i>Recovery high school/college</i>	(2) B; C	<i>Recovery high school/college</i>	(0)
Afterschool services	(1) B	Afterschool services	(1) 41
Professionally supervised recovery dorm	(1) B	Professionally supervised recovery dorm	(1) 15
<i>Funding for basic needs</i>	(1) A	<i>Funding for basic needs</i>	(0)
<i>Comprehensive student assistance programs</i>	(1) C	<i>Comprehensive student assistance programs</i>	(0)
<i>Art-related activities and public arenas to highlight</i>	(1) C	<i>Art-related activities and public arenas to highlight</i>	(0)
<i>Faith-based community support groups</i>	(1) C	<i>Faith-based community support groups</i>	(0)
Education and training	(0)	Education and training	(3) 18, 42, 64
Skill development	(0)	Skill development	(3) 26, 30, 32
Substance abuse education	(0)	Substance abuse education	(1) 42
Supported community living	(0)	Supported community living	(1) 21
Independent living	(0)	Independent living	(1) 41
Specialized educational services	(0)	Specialized educational services	(1) 41
Community service activities	(0)	Community service activities	(3) 21, 53, 78
Vocational training/career development/employment support	(0)	Vocational training/career development/employment support	(2) 13, 32
Jobs	(0)	Jobs	(1) 64
Household management	(0)	Household management	(1) 41
Tutors	(0)	Tutors	(1) 41
Total	(4) A; B; C; D	Total	(14) 13, 15, 18, 21, 25, 26, 30, 32, 41, 42, 53, 64, 76, 78

Recovery Services and Supports Comparison Tables (cont.)

Note: In the following tables, “Total” indicates the unduplicated count of group endorsements or literature citations. Under “Literature Citations,” the number in parenthesis refers to the total number of times the item appears in the reviewed literature. The following numbers refer to the numbered sources in the bibliography for the recovery consultative session briefing materials (see Appendix I).

Fostering social connectedness

Element	Group Endorsements	Element	Literature Citations
Mentors	(2) B; C	Mentors	(1) 41
Aftercare groups	(0)	Aftercare groups	(1) 78
Self-help support groups	(0)	Self-help support groups	(2) 32, 42
Opportunities for community service integration	(0)	Opportunities for community service integration	(1) 59
Secular organizations for sobriety	(0)	Secular organizations for sobriety	(1) 15
Women in sobriety	(0)	Women in sobriety	(1) 15
Service projects	(0)	Service projects	(1) 15
Living with others in recovery	(0)	Living with others in recovery	(1) 26
Volunteers	(0)	Volunteers	(1) 78
Local recovery celebration events	(0)	Local recovery celebration events	(1) 78
Mutual aid support groups	(0)	Mutual aid support groups	(1) 7
Total	(2) B; C	Total	(8) 7, 15, 26, 32, 41, 42, 59, 78

Providing specialized recovery supports

Element	Group Endorsements	Element	Literature Citations
Internet-based support tools	(2) B; C	Internet-based support tools	(2) 34, 78
Recovery coach/consultant	(1) B	Recovery coach/consultant	(5) 10, 42, 43, 78, 80
Recovery groups	(1) B	Recovery groups	(1) 78
Recovery checkups	(0)	Recovery checkups	(4) 23, 55, 62, 81
Outreach	(0)	Outreach	(2) 18, 53
Recovery home	(0)	Recovery home	(2) 18, 78
Telephone contact	(0)	Telephone contact	(2) 32, 78
Interactive voice response systems	(0)	Interactive voice response systems	(1) 78
Voucher-based incentives	(0)	Voucher-based incentives	(1) 78
Peer leader, guide, escort	(0)	Peer leader, guide, escort	(3) 18, 21, 78
Recovery support specialists	(0)	Recovery support specialists	(2) 43, 78
Sponsors	(0)	Sponsors	(2) 15, 26
Job coach	(0)	Job coach	(1) 41
Total	(2) B; C	Total	(17) 10, 15, 18, 21, 23, 26, 32, 34, 41, 42, 43, 53, 55, 62, 78, 80, 81

Recovery Services and Supports Comparison Tables (cont.)

Note: In the following tables, “Total” indicates the unduplicated count of group endorsements or literature citations. Under “Literature Citations,” the number in parenthesis refers to the total number of times the item appears in the reviewed literature. The following numbers refer to the numbered sources in the bibliography for the recovery consultative session briefing materials (see Appendix I).

Providing therapeutic and clinical interventions

Element	Group Endorsements	Element	Literature Citations
Therapy and clinical interventions	(2) A; B	Therapy and clinical interventions	(1) 66
Crisis management stabilization	(1) B	Crisis management stabilization	(2) 53, 66
Relapse prevention	(0)	Relapse prevention	(3) 32, 42, 78
Evidence-based practices	(0)	Evidence-based practices	(3) 30, 32, 53
Strength-based assessment	(0)	Strength-based assessment	(2) 53, 78
Screening	(0)	Screening	(2) 53, 78
Emotion/anger management	(0)	Emotion/anger management	(1) 18
Mental health counseling	(0)	Mental health counseling	(1) 78
Motivational interviewing	(0)	Motivational interviewing	(1) 21
Behavioral aides	(0)	Behavioral aides	(1) 41
Residential treatment	(0)	Residential treatment	(1) 41
Inpatient treatment	(0)	Inpatient treatment	(1) 41
Therapeutic foster care	(0)	Therapeutic foster care	(1) 41
Therapeutic group homes	(0)	Therapeutic group homes	(1) 41
Total	(2) A; B	Total	(9) 18, 21, 30, 32, 41, 42, 53, 66, 78

Providing ancillary supports

Element	Group Endorsements	Element	Literature Citations
<i>Legal advocacy</i>	(1) D	<i>Legal advocacy</i>	(0)
Transportation	(0)	Transportation	(4) 32, 41, 42, 78
Child care	(0)	Child care	(2) 42, 78
Total	(1) D	Total	(4) 32, 41, 42, 78

Recovery Infrastructure Comparison Tables

Note: In the following tables, “Total” indicates the unduplicated count of group endorsements or literature citations. Under “Literature Citations,” the number in parenthesis refers to the total number of times the item appears in the reviewed literature. The following numbers refer to the numbered sources in the bibliography for the recovery consultative session briefing materials (see Appendix I).

The infrastructure underlying a recovery-oriented system of care should assure:

Family involvement at the design/policy level

Element	Group Endorsements	Element	Literature Citations
<i>Youth/family/parent advocacy and partnership/equal partnership</i>	(2) C; D	<i>Youth/family/parent advocacy and partnership/equal partnership</i>	(0)
Youth and families in decision-making/policy-making roles (leaders in recovery)	(1) A	Youth and families in decision-making/policy-making roles (leaders in recovery)	(2) 1, 18
<i>Infrastructure support for youth and family involvement</i>	(1) B	<i>Infrastructure support for youth and family involvement</i>	(0)
Total	(4) A; B; C; D	Total	(2) 1, 18

Policy change at the Federal, State, and provider levels

Element	Group Endorsements	Element	Literature Citations
Policy	(2) A; D	Policy	(1) 53
<i>State advisory/policy board to make recommendations</i>	(1) B	<i>State advisory/policy board to make recommendations</i>	(0)
Recovery representation at policy and clinical decision-making levels	(0)	Recovery representation at policy and clinical decision-making levels	(1) 78
Total	(3) A; B; D	Total	(2) 53, 78

Recovery Infrastructure Comparison Tables (cont.)

Note: In the following tables, “Total” indicates the unduplicated count of group endorsements or literature citations. Under “Literature Citations,” the number in parenthesis refers to the total number of times the item appears in the reviewed literature. The following numbers refer to the numbered sources in the bibliography for the recovery consultative session briefing materials (see Appendix I).

Collaborative financing

Element	Group Endorsements	Element	Literature Citations
Financing	(2) A; D	Financing	(1) 12
Blended/braided funding	(2) A; C	Blended/braided funding	(2) 12, 53
<i>Performance-based contracting</i>	(1) A	<i>Performance-based contracting</i>	(0)
<i>Purchasing strategies, including recovery support services</i>	(1) C	<i>Purchasing strategies, including recovery support services</i>	(0)
Joint purchasing	(0)	Joint purchasing	(1) 64
Adequate capitalization	(0)	Adequate capitalization	(1) 78
Funding diversification	(0)	Funding diversification	(1) 78
Money must follow the person	(0)	Money must follow the person	(1) 64
Availability of funding streams that assure sustained support	(0)	Availability of funding streams that assure sustained support	(1) 78
No outcomes, no income	(0)	No outcomes, no income	(1) 21
Person selects provider	(0)	Person selects provider	(1) 21
Protection from undue influence	(0)	Protection from undue influence	(1) 21
Providers don't oversee themselves	(0)	Providers don't oversee themselves	(1) 21
Providers compete for business	(0)	Providers compete for business	(1) 21
Total	(3) A; C; D	Total	(5) 12, 21, 53, 64, 78

Collaboration and integration across all youth-serving systems

Element	Group Endorsements	Element	Literature Citations
System collaboration and integration across key systems	(2) B; C	System collaboration and integration across key systems	(1) 53
Institutional relationships with local communities	(0)	Institutional relationships with local communities	(1) 78
Total	(2) B; C	Total	(2) 53, 78

Recovery Infrastructure Comparison Tables (cont.)

Note: In the following tables, “Total” indicates the unduplicated count of group endorsements or literature citations. Under “Literature Citations,” the number in parenthesis refers to the total number of times the item appears in the reviewed literature. The following numbers refer to the numbered sources in the bibliography for the recovery consultative session briefing materials (see Appendix I).

Workforce development

Element	Group Endorsements	Element	Literature Citations
Workforce development	(2) A; B	Workforce development	(2) 53, 69
<i>Competencies</i>	(2) A; C	<i>Competencies</i>	(0)
<i>Curriculum development</i>	(1) A	<i>Curriculum development</i>	(0)
<i>Licensing</i>	(1) A	<i>Licensing</i>	(0)
<i>Recruitment</i>	(1) A	<i>Recruitment</i>	(0)
<i>Retention</i>	(1) A	<i>Retention</i>	(0)
<i>Equitable salaries</i>	(1) A	<i>Equitable salaries</i>	(0)
<i>Supervision and clinical oversight</i>	(1) A	<i>Supervision and clinical oversight</i>	(0)
<i>EBPs</i>	(1) A	<i>EBPs</i>	(0)
Workforce stability	(0)	Workforce stability	(1) 78
Safety protocols for service providers and consumers	(0)	Safety protocols for service providers and consumers	(1) 78
Knowledge adoption	(0)	Knowledge adoption	(1) 26
<i>Training</i>	(0)	<i>Training</i>	(0)
Total	(3) A; B; C	Total	(4) 26, 53, 69, 78

Leadership

Element	Group Endorsements	Element	Literature Citations
<i>Leadership committed to principles of recovery and youth</i>	(2) B; D	<i>Leadership committed to principles of recovery and youth</i>	(0)
Leaders in recovery—boards, decision-makers, etc	(1) A	Leaders in recovery—boards, decision-makers, etc	(2) 1, 18
Strong administrative and clinical leadership	(0)	Strong administrative and clinical leadership	(2) 26, 78
Total	(3) A; B; D	Total	(4) 1, 18, 26, 78

Recovery Infrastructure Comparison Tables (cont.)

Note: In the following tables, “Total” indicates the unduplicated count of group endorsements or literature citations. Under “Literature Citations,” the number in parenthesis refers to the total number of times the item appears in the reviewed literature. The following numbers refer to the numbered sources in the bibliography for the recovery consultative session briefing materials (see Appendix I).

Accountability

Element	Group Endorsements	Element	Literature Citations
<i>Quality assurance and performance measurement/ monitoring for all providers including nontraditional providers</i>	(2) A; C	<i>Quality assurance and performance measurement/ monitoring for all providers including nontraditional providers</i>	(0)
Continuous quality improvement (CQI)	(1) B	Continuous quality improvement (CQI)	(1) 10
Evaluation of complex adaptive systems	(1) C	Evaluation of complex adaptive systems	(1) 10
Total	(3) A; B; C	Total	(1) 10

Systems management

Element	Group Endorsements	Element	Literature Citations
Planning	(1) D	Planning	(2) 53, 64
Technology (application/ capability)	(1) B	Technology (application/ capability)	(2) 10, 78
Systems management	(0)	Systems management	(1) 53
Provider network	(0)	Provider network	(1) 53
Stability of provider organizational ownership	(0)	Stability of provider organizational ownership	
Communication	(0)	Communication	(1) 53
Contracting	(0)	Contracting	(1) 64
Interagency supervision/ oversight	(0)	Interagency supervision/ oversight	(1) 73
Governance	(0)	Governance	(2) 53, 73
Recovery-focused organizational culture	(0)	Recovery-focused organizational culture	(1) 78
Total	(2) B; D	Total	(5) 10, 53, 64, 73, 78

Utilization management

Element	Group Endorsements	Element	Literature Citations
Utilization management	(0)	Utilization management	(1) 53
Clinical algorithms/ decision support	(0)	Clinical algorithms/ decision support	(2) 10, 26
Total	(0)	Total	(3) 10, 26, 53

Appendices H and I contain material included in the recovery consultative session briefing materials

Appendix H

Values, Principles, Services, Supports, and Infrastructure

Tables Included in Recovery Consultative Session Resource Materials

Table 1: Values encouraged by a recovery-oriented system

Note: The number in parenthesis refers to the total number of times the item appears in the reviewed literature. The following numbers refer to the numbered sources in the bibliography consultative session briefing materials (see Appendix I).

Item	Literature Citations
Hope	(12) 5, 10, 16, 18, 21, 27, 28, 36, 51, 52, 63, 75
Strengths based	(9) 10, 11, 16, 18, 21, 27, 29, 73, 74
Providing choice	(9) 5, 11, 18, 19, 21, 28, 29, 36, 60
Person/client centered	(7) 10, 16, 18, 21, 26, 27, 66
Self-directed	(7) 10, 16, 18, 21, 26, 28, 60
Empowering	(7) 10, 16, 18, 19, 27, 36, 54
Accessible	(7) 19, 21, 42, 53, 64, 78, 84
Responsibility	(7) 16, 19, 20, 26, 27, 28, 84
Engaging	(6) 10, 18, 42, 67, 78, 84
Promoting resilience	(6) 18, 19, 28, 51, 81, 83
Nonlinear nature of recovery	(6) 16, 18, 27, 28, 29, 36
Respecting spiritual, religious, secular beliefs	(5) 18, 36, 38, 77, 78
Holistic	(5) 10, 16, 18, 27, 36
Family voice	(5) 18, 28, 53, 64, 73
Family involvement	(5) 18, 27, 29, 66, 67
Client participation at all levels	(4) 18, 21, 26, 28
Optimism	(4) 10, 27, 28, 75
Providing social opportunities	(3) 10, 18, 38
Evidence based	(3) 10, 18, 26
Opportunity to take risk to fail	(3) 20, 21, 22
Secure bases	(3) 8, 9, 63
Responsiveness to cultural belief systems—cultural competency	(3) 18, 21, 78
Consumer autonomy/independence	(2) 18, 77
Learning from success/mistake	(2) 21, 22
Consumer rights	(2) 20, 21
Equal opportunity for wellness	(2) 18, 21
Future orientation	(2) 27, 28
Flexibility	(2) 11, 18
Improving quality of life	(2) 3, 27
Self-esteem/self-worth	(2) 18, 68
Normalize/respect	(2) 10, 16
Ecological system/perspective	(2) 29, 36
Optimism	(2) 27, 28
Rooted in reality	(1) 18
Long-term perspective	(1) 29
Transformative	(1) 36
Developmental approach	(1) 36
Incorporating illness	(1) 19
Redefining self	(1) 19
Persistence	(1) 11

Table 1: Values encouraged by a recovery-oriented system (cont.)

Note: The number in parenthesis refers to the total number of times the item appears in the reviewed literature. The following numbers refer to the numbered sources in the bibliography consultative session briefing materials (see Appendix I).

Item	Literature Citations
Personal vision	(1) 74
Opportunity	(1) 77
Supportive environment	(1) 18
Accept client as s/he is	(1) 18
Wellness focus	(1) 18
Youth involvement	(1) 53
Empowering parents	(1) 53
Positive youth development focus	(1) 28

Table 2: Principles espoused by a recovery-oriented system

Note: The number in parenthesis refers to the total number of times the item appears in the reviewed literature. The following numbers refer to the numbered sources in the bibliography consultative session briefing materials (see Appendix I).

Item	Literature Citations
Individualized	(12) 5, 10, 11, 16, 18, 21, 26, 27, 36, 64, 66, 84
Coordinated	(8) 11, 18, 26, 27, 53, 64, 66, 78
Community-based	(8) 10, 11, 18, 27, 42, 53, 66, 78
Culturally competent	(7) 11, 18, 21, 27, 28, 50, 66
No wrong door	(5) 18, 19, 21, 53, 64
Peer-run programs	(4) 18, 27, 43, 78
Collective fiscal responsibility	(4) 18, 26, 53, 72
Comprehensive	(4) 18, 27, 28, 66
Nondiscriminatory	(4) 10, 18, 21, 27
Addresses relapse	(4) 5, 18, 28, 36
Continuous/continuity of care	(3) 10, 18, 26
Many pathways	(3) 11, 18, 36
Broad array of services and supports	(3) 18, 26, 64
Long-term recovery focus	(3) 10, 18, 64
Single wraparound plan	(3) 11, 53, 72
Encourages client to expand and occupy normal, functional social roles	(3) 19, 21, 29
Addresses recovery capital	(3) 33, 78, 82
Provider competition/accountability	(2) 21, 72
Partnership/consultant relationship	(2) 10, 18
Supports consumer to rebuild life in community	(2) 18, 78
Provides structure/rules	(2) 18, 77
Assures speedy reentry into treatment	(2) 21, 78
New nomenclature	(2) 21, 53
Outcomes driven	(2) 11, 18
Commitment to peer support and to consumer-operated services	(1) 21
Entry at any time	(1) 21
Collaborative	(1) 18
Age appropriate	(1) 42
Gender appropriate	(1) 42

Table 2: Principles espoused by a recovery-oriented system (cont.)

Note: The number in parenthesis refers to the total number of times the item appears in the reviewed literature. The following numbers refer to the numbered sources in the bibliography consultative session briefing materials (see Appendix I).

Item	Literature Citations
Employs chronic disorder management approach	(1) 18
Financial support for consumer participation	(1) 21
Continuous support	(1) 72
Positive reinforcement	(1) 18
Recovery encompasses all phases of care	(1) 21
Service duration	(1) 78
Menu of services	(1) 18
Flexible	(1) 18
Adaptable to client need	(1) 18
Continuing care	(1) 18
Integrated services	(1) 18
Outreach	(1) 18
Flexibly financed	(1) 18
Family-focused treatment	(1) 78
Family driven	(1) 50
Youth guided	(1) 50
Array of services	(1) 18
Consumer-driven plan of care	(1) 64
Follow-up	(1) 64
Early identification	(1) 64
Statewide	(1) 21
Least restrictive setting	(1) 11
Service integration	(1) 10
Organizational change	(1) 26
Strengths-based	(1) 66

Table 3: Services to be included in a recovery-oriented system

Note: The number in parenthesis refers to the total number of times the item appears in the reviewed literature. The following numbers refer to the numbered sources in the bibliography consultative session briefing materials (see Appendix I).

Item	Literature Citations
Case management link to services/supports	(8) 11, 18, 30, 32, 41, 42, 64, 78
Continuing care with contacts	(4) 18, 30, 32, 78
Recovery checkups	(4) 23, 55, 62, 81
Transportation	(4) 32, 41, 42, 78
Education and training	(3) 18, 42, 64
Relapse prevention	(3) 32, 42, 78
Skill development	(3) 26, 30, 32
Evidence-based practices	(3) 30, 32, 53
Strengths-based assessment	(2) 53, 78
Outreach	(2) 18, 53
Screening and assessment	(2) 53, 78
Recovery home	(2) 18, 78
Child care	(2) 42, 78
Crisis management/stabilization	(2) 53, 66
Housing assistance and services	(2) 41, 42
Telephone contact	(2) 32, 78
Emotion/anger management	(1) 18
Continuous evaluation	(1) 10
Family/marriage education	(1) 42
Life skills training	(1) 42
Substance abuse education	(1) 42
Family team	(1) 64
The health/recovery system	(1) 26
Vocational training and assistance	(1) 78
Aftercare groups	(1) 78
Interactive voice response systems	(1) 78
Mental health counseling	(1) 78
Voucher-based incentives	(1) 78
Multiagency teams	(1) 78
Motivational interviewing	(1) 21
Supported community living	(1) 21
Therapy and clinical interventions	(1) 66
Behavioral aides	(1) 41
Residential treatment	(1) 41
Inpatient treatment	(1) 41
Therapeutic foster care	(1) 41
Therapeutic group homes	(1) 41
Independent living	(1) 41
Afterschool services	(1) 41
Specialized educational services	(1) 41
Parent aides	(1) 41
Parent counseling	(1) 32

Table 4: Supports to be included in a recovery-oriented system

Note: The number in parenthesis refers to the total number of times the item appears in the reviewed literature. The following numbers refer to the numbered sources in the bibliography consultative session briefing materials (see Appendix I).

Item	Literature Citations
Recovery coach/consultant	(5) 10, 42, 43, 78, 80
Peer leader, guide, escort	(3) 18, 21, 78
Community services activities	(3) 21, 53, 78
Family support	(3) 14, 18, 53
Social support	(3) 15, 32, 76
Recreational opportunities	(3) 25, 30, 32
Post-treatment monitoring	(2) 10, 78
Post-treatment support	(2) 10, 78
Recovery support specialists	(2) 43, 78
Sponsors	(2) 15, 26
Parent support group	(2) 18, 64
Transitions planning	(2) 18, 41
Internet-based support tools	(2) 34, 78
Vocational training, career development, employment support	(2) 13, 32
Self-help support groups	(2) 32, 42
Informal community supports	(1) 25
Opportunities for community service integration	(1) 59
Family support	(1) 10
Professionally supervised recovery dorm	(1) 15
Secular organizations for sobriety	(1) 15
Women for sobriety	(1) 15
Service projects	(1) 15
Living with others in recovery	(1) 26
Volunteers	(1) 78
Local recovery celebration events	(1) 78
Recovery groups	(1) 78
Systematic encouragement	(1) 78
Mutual aid support groups	(1) 7
Jobs	(1) 64
Household management	(1) 41
Mentors	(1) 41
Tutors	(1) 41
Job coach	(1) 41

Table 5: Elements of infrastructure for a recovery-oriented system

Note: The number in parenthesis refers to the total number of times the item appears in the reviewed literature. The following numbers refer to the numbered sources in the bibliography consultative session briefing materials (see Appendix I).

Item	Literature Citations
System collaboration and integration across key systems including Mental Health, Substance Abuse, Health, Human Services, Education, Labor and Employment, Juvenile Justice, Child Welfare, Housing, Transportation, Medicaid, Developmental Disabilities, Child Care, and Early Childhood	(1) 53
Systems Management and Operations	(1) 53
• Utilization management	(1) 53
• Clinical algorithms/decision support	(2) 10, 26
• Provider network	(1) 53
• Communication	(1) 53
• Contracting	(1) 64
Financing	(1) 12
• Blended and braided funding	(2) 12, 53
• Joint purchasing	(1) 64
• Adequate capitalization	(1) 78
• Funding diversification	(1) 78
• Money must follow the person	(1) 64
• Availability of funding streams that assure sustained support	(1) 78
Development of a recovery-oriented philosophy of financing	
• No outcomes, no income	(1) 21
• Person selects provider	(1) 21
• Protection from undue influence	(1) 21
• Providers don't oversee themselves	(1) 21
• Providers compete for business	(1) 21
Workforce Development	(2) 53, 69
• Workforce stability	(1) 78
• Safety protocols for service providers and consumers	(1) 78
• Knowledge adoption	(1) 26
Evaluation of complex adaptive system	(1) 10
Leaders in recovery—boards, decision-makers, etc.	(2) 1, 18
Interagency supervision/oversight	(1) 73
Governance	(2) 53, 73
Planning	(2) 53, 64
Application of technology	(1) 10
Policy	(1) 53
System management and operations	(1) 53
Recovery-focused organizational culture	(1) 78
Stability of provider organizational ownership	(1) 78
Strong administrative and clinical leadership	(2) 26, 78
Recovery representation at policy and clinical decision-making levels	(1) 78
Technological capabilities	(1) 78
Institutional relationships with local communities (with particular emphasis on communities of recovery)	(1) 78

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* This bibliography resulted from a snowball nomination approach employed by consultative session planners to identify seminal documents in the published literature as well as Federal government papers and reports. The findings from this review informed the development of a briefing document sent to all consultative session participants prior to the meeting.

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