

Strategic Initiative #4: Recovery Support

Lead: Kathryn Power, Director, Center for Mental Health Services

Key Facts

- For those with substance use disorders, a comprehensive array of services assists recovery from substance use disorders,⁶⁵ and social supports improve recovery outcomes.⁶⁶
- A study has shown that at 24 months' followup, individuals entering Oxford House (supported housing) after substance use disorders treatment had significantly lower substance use, significantly higher monthly income, and significantly lower incarceration rates than did those entering usual care.⁶⁷
- One-third of individuals with severe mental illnesses who receive community mental health services after lengthy stays in a State hospital achieve full recovery in psychiatric status and social function and another third improve significantly in both areas.⁶⁸
- Of the more than 6 million people served by State mental health authorities across the Nation, only 21 percent are employed. Despite this exceptionally low rate, only 2.1 percent of people served receive evidence-based supported employment services.⁶⁹
- A qualitative study found that 33 percent of those who reported having dropped out of treatment indicated they might have stayed longer in substance abuse treatment if they had received practical assistance, help with areas of life functioning, and better individualized services.⁷⁰
- Supported employment programs that help people with the most serious mental illnesses place more than 50 percent of their clients into paid employment.⁷¹
- In 2009, more than half of the 4.3 million persons aged 12 and older who received treatment for alcohol or illicit drug use in the past year received that treatment at a self-help group.⁷²
- A recent 10-year study suggests that supported employment initiatives for people who are high users of mental health services can reduce their need for such services, saving public funding over time.⁷³
- In 2006, 13 percent of admissions to substance abuse treatment were homeless.⁷⁴
- Sixty-four percent of persons who are homeless have an alcohol or substance use disorder.⁷⁵
- One-third (32.7 percent) of individuals aged 12 and older who attended a self-help group for substance abuse in the past year also received specialty treatment for substance use during that same period.⁷⁶
- Conversely, 66 percent of persons aged 12 and older who received any alcohol or illicit drug use specialty treatment in the past year also attended a self-help group during the same time frame.⁷⁷

- Research indicates that a combination of long-term housing, treatment, and life affirming services leads to improved residential stability and reductions in substance use and psychiatric symptoms.⁷⁸
- In one research study, providing housing for individuals with mental illness who are homeless reduced criminal justice involvement by 38 percent and prison days by 84 percent.⁷⁹
- More than half of adolescents in the United States who fail to complete high school have a diagnosable psychiatric disorder. The proportion of failure to complete school that is attributable to psychiatric disorder is estimated to be 46 percent.⁸⁰

Overview

Behavioral health problems are more common in the United States than is generally realized. According to estimates from the 2009 National Survey on Drug Use and Health, approximately 20 percent of persons aged 18 and older reported having a diagnosable mental illness in the previous year, 9 percent of persons aged 12 and older reported using an illicit drug in the past

Purpose of Initiative #4

Partnering with people in recovery from mental and substance use disorders and family members to guide the behavioral health system and promote individual-, program-, and system-level approaches that foster health and resilience; increase permanent housing, employment, education, and other necessary supports; and reduce discriminatory barriers.

month, and 24 percent reported binge alcohol use (i.e., drinking five or more drinks on the same occasion) at least once in the past month.⁸¹ Mental and substance use disorders often occur together as well as with general medical conditions, such as diabetes or heart disease. In fact, those admitted to treatment reporting psychiatric problems in addition to substance abuse problems more than doubled between 1992 and 2006.⁸²

Recovery is a unique journey for each individual, and each person in recovery must choose the range of services and supports ranging from clinical treatment to peer services. To facilitate resilience, recovery, and social inclusion, persons with mental and substance use disorders will also likely need to receive treatment for their co-occurring

health problems. Access to services must be paired with shared decisionmaking process between people in recovery and providers to determine how best to select, structure, and deliver services. Like other aspects of health care and unless adjudicated by courts of law, people have the right to choose and determine what services and treatments best meet their needs and preferences. Self-determination is the foundation of person-centered and consumer-driven recovery supports and systems, including such approaches as person-centered planning, shared decisionmaking, and peer-operated services. People in recovery should be meaningfully involved in all aspects of behavioral health services, including planning, policy development, training, delivery, administration, and research.

The goal of recovery is exemplified through a life that includes:

- **Health**—Overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way;

- **Home**—A stable and safe place to live that supports recovery;
- **Purpose**—Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society; and
- **Community**—Relationships and social networks that provide support, friendship, love, and hope.

These elements—*health, home, purpose, and community*—are central to recovery from mental and substance use disorders. An individual's ability to have a successful, satisfying, and healthy life integrated in a community is fostered through the availability of and appropriate use of prevention, health, clinical treatment (including residential treatment if needed), and recovery support services that are culturally appropriate, and directed by persons in recovery (and family members as appropriate). Recovery is also supported by getting and maintaining, as needed, accessible, affordable housing with supportive services; mainstream jobs that pay a living wage; and accessible educational opportunities. Finally, to support recovery, communities should welcome everyone, regardless of condition or disabilities, as full, participating members in every facet of American life.

To recover, people need good health. Research reveals the startling fact that individuals with the most serious mental illnesses and co-occurring disorders die at age 53, on average.⁸³ They die from treatable medical conditions caused by modifiable risk factors, including smoking, obesity, high blood pressure, and substance use. Unfortunately, these deaths often stem from inadequate access to overall medical care. There is increasing recognition that most serious behavioral health disorders can be long-term conditions and that they frequently co-occur with, and may exacerbate, other medical conditions. However, individuals who have serious behavioral health conditions and lack financial resources are often unable to access quality care, either for their behavioral health conditions or for other health problems. Properly addressing behavioral health conditions is necessary because untreated mental and substance use disorders not only negatively impact a person's behavioral health but also lead to worse outcomes for co-occurring physical health problems. Good behavioral health is associated with better physical health outcomes, improved educational attainment, increased economic participation, and meaningful social relationships.⁸⁴ In fact, good health is not possible without good behavioral health.

To recover, people need a safe, stable place to live. The number of people experiencing homelessness on any given night in the United States is estimated at more than 643,000. Due to the current economic downturn, this number may increase. Approximately 63 percent are individuals, and 37 percent are adults with children. Although Federal, State, and Territorial policies have been successful in beginning to reduce the number of individuals and veterans who are chronically homeless, the number of families that are homeless at any time during a year has increased about 30 percent since 2007.⁸⁵ Permanent supportive housing has emerged as a model in which individuals who have mental and substance use disorders can secure stable housing and receive the range of supports they need to manage mental illnesses or other disabilities. Research and practice reveal that supportive housing decreases symptoms, increases housing stability, and is cost effective. For many in recovery from substance use disorders short term drug-free housing may be essential to achieving long-term recovery. A recent study found that residents in a Sober

Housing program linked to outpatient substance abuse treatment showed decreases in the number of months using substances and maximum number of days of substance use per month, reduced arrests, and increased rates of employment. Seventy-six percent of the residents in the study remained in the house at least 5 months, and 39 percent reported being employed at some point during the past 30 days.⁸⁶ Such “recovery housing” can be provided through a variety of models ranging from peer-run, self-supported, drug-free homes to community-based housing that includes a range of supportive services.

To recover, people need meaningful work and the ability to enhance their skills through education. Employment by its very nature helps integrate individuals in society and acknowledges their ability to contribute. In 2009, unemployed adults were classified with substance dependence or abuse at a higher rate (16.6 percent) than were full- or part-time employed adults (9.6 percent and 11.2 percent, respectively).⁸⁷ The income employment produces enables people to improve their living situation, reducing exposure to violence and other stressors that may adversely affect behavioral health. Conversely, being unemployed is associated with increased rates of mental disorders, especially among men,⁸⁸ and with relapse to substance use.^{89,90,91,92} Employment is recognized as a factor in preventing and ending homelessness among people with disabilities; for many individuals, it helps develop motivation and hope for the future. Nevertheless, individuals with mental disabilities have the lowest earning level and household income of any disability group.⁹³ People who are unemployed show higher rates of substance dependence or abuse than those who are employed full or part time.

Education is closely linked to opportunities for work, yet individuals with mental and substance use disorders have the lowest educational attainment level of any disability group. Mental illnesses often begin when young adults are completing high school and looking at future opportunities and career plans. The same holds true for those with substance dependence or abuse. In 2009, college or university graduates had a lower rate of dependence or abuse (7.5 percent) than those who graduated from high school (8.9 percent), those who did not graduate from high school (11.6 percent), and those with some college (9.9 percent).⁹⁴ Supported education is a promising practice that allows individuals with behavioral health problems to enroll and remain in an educational program.

To recover, individuals need to be full, participating members of their communities. Individuals with behavioral health conditions do not recover in isolation—they recover in families and community. However, living *in* the community is necessary but not sufficient for individuals with behavioral health disorders to be included fully in society. Even if they live in neighborhoods alongside people without disabilities, individuals with substance use and mental conditions may lack socially valued activity, adequate income, personal relationships, recognition and respect from others, and a political voice. They remain, in a very real sense, socially excluded.⁹⁵ The exclusion comes from society’s attitudes and fears about persons with mental and substance use disorders as much or more than from any disability associated with these disorders.

As observers have noted, insufficient natural structures exist in the community to involve persons with mental and substance use disorder in shared social activities, either with peers or with members of the community at large.⁹⁶ Mutual support groups play a critical role for many,

but there is still an unmet need. A person with a behavioral health condition is as capable of living a full life integrated in a community as anyone else. Successful recovery from mental and substance use disorders is an important societal goal, especially attainment of levels of recovery that enhance economic security and reduce reliance on government-funded disability income support programs. Innovative programs promoting economic resiliency (and reducing poverty-related behavioral health risks) can be used effectively, in combination with other programs of rehabilitation and support, to increase and accelerate the likelihood of recovery for those with behavioral health illnesses. The role of the Substance Abuse and Mental Health Services (SAMHSA)—in collaboration with partners at the Federal, State, Territorial, Tribal, and local level—is to help remove attitudinal barriers and establish appropriate supports to make this possible. The goal is for people with behavioral health conditions to *flourish*, not merely function, in their communities.

Health Reform

The passage of the Affordable Care Act recognizes that an individual's health and behavioral health care are interwoven and that both must be appropriately addressed to achieve successful health outcomes. Several provisions of the Affordable Care Act support an integrated approach to care, and SAMHSA will work to ensure that this integrated approach supports recovery from mental and substance use disorders. The challenge in achieving the promise of integrated physical and behavioral health care is that it requires structural, policy, practice, and cultural and financial changes to our health care systems as well as to our social service systems. Recognizing the size and complexity of this undertaking, SAMHSA is using this Strategic Initiative and action plan as the foundation to support transformational change. SAMHSA will engage stakeholders and partners within and outside of the behavioral health field to understand and embrace recovery and all of its dimensions as the appropriate course to follow. SAMHSA will also work through this Initiative to ensure that coverage expansions under the Affordable Care Act are met with recovery supports.

Behavioral Health Workforce

Workforce development issues have an impact on almost every aspect of prevention and treatment across all sectors of the diverse behavioral health field. The majority of the U.S. behavioral workforce will need support and training in understanding and providing behavioral health promotion and prevention activities to supplement their current training in treatment. This Initiative supports the future development of the behavioral health workforce and builds an understanding of recovery-oriented practices, including incorporating peers into the current workforce to support peer-run services. It also emphasizes collaborative relationships with children, youth, and families that involve shared decisionmaking service options. This Initiative will leverage public and private relationships, provide technical assistance, and facilitate systems and services to demonstrate that recovery with behavioral health conditions is possible. Through the action steps outlined below, SAMHSA will support the development of a capable, recovery-oriented workforce in partnership with grantees, States, Territories, Tribes, communities, families, and individuals.

Disparities

Many racial and ethnic groups face elevated levels of substance use disorders and experience higher suicide rates than the general population. They also have higher rates of certain risk factors for mental, emotional, and behavioral problems, including poverty, domestic violence, and childhood and historical trauma as well as involvement in the foster care and criminal justice systems. Behavioral health disparities are also present for American Indian and Alaska Native communities and Tribes; people with disabilities; lesbian, gay, bisexual, transgender, and questioning (LGBTQ) individuals; girls; and transition-aged youth. SAMHSA is committed to addressing these disparities by improving prevention, treatment, and recovery support programs that serve members of these groups. In particular, SAMHSA will work with Tribes to develop culturally focused and person-centered health and wellness initiatives and housing supports that are also person driven whenever and to the greatest extent possible.

Components of Initiative

No single program, either within the U.S. Department of Health and Human Services (HHS) or anywhere else in the Federal Government, can solve the problems of homelessness, joblessness, educational challenges, and community cohesion for people with mental and substance disorders. Coordination of programs and the piecing together of the various resources offered throughout the Federal Government are necessary to provide the full range of recovery support and behavioral health service options needed at the State, Territorial, and community level to effectively serve persons and families to thrive in their communities. This Strategic Initiative aligns with current Administration efforts to expand opportunities for individuals with disabilities to live in integrated, community settings. Through this Initiative, SAMHSA can serve as the lead Federal agency for promoting and increasing practices for individuals to recover and for their communities to support and welcome them.

Goals

- Goal 4.1: (Health)** Promote health and recovery-oriented service systems for individuals with or in recovery from mental and substance use disorders.
- Goal 4.2: (Home)** Ensure that permanent housing and supportive services are available for individuals with or in recovery from mental and substance use disorders.
- Goal 4.3: (Purpose)** Increase gainful employment and educational opportunities for individuals with or in recovery from mental and substance use disorders.
- Goal 4.4: (Community)** Promote peer support and the social inclusion of individuals with or in recovery from mental and substance use disorders in the community.

Specific Goals, Objectives, and Action Steps

Goal 4.1: (Health) Promote health, recovery-oriented service systems and peer support for individuals with or in recovery from mental and substance use disorders.

Objective 4.1.1: Promote health, wellness, and resiliency.

Action Steps:

1. Initiate and sustain a national campaign to promote health and wellness among individuals with mental and substance use disorders and/or in recovery. The campaign should build on the updated Recovery Month campaign that now applies to recovery from both mental and substance use disorders and conditions, as well as the 10 By 10 Campaign.

Objective 4.1.2: Promote recovery-oriented service systems.

Action Steps:

1. Finalize and disseminate a consensus statement on recovery from mental and substance use disorders.
2. Develop and disseminate recovery-oriented service protocols for behavioral health providers.
3. Develop and disseminate facility and organizational standards for recovery-oriented behavioral health care in behavioral health settings.
4. Provide training and technical assistance on recovery and recovery-oriented systems, services, and supports to State, Territorial, Tribal, and local officials (e.g., Commissioners of Behavioral Health, Commissioners of Mental Health Services, Single State Authorities for Substance Abuse Services, National Prevention Network members, Public Health Commissioners, Superintendents of Education, Correctional Commissioners, County Commissioners, and State Judges) on how to develop and implement and/or update strategic plans that include specific efforts to move systems and services toward a recovery orientation through the new Recovery Support TA Center.
5. Provide training and technical assistance on recovery and recovery-oriented systems, services, and supports to program administrators, policymakers, clinical supervisors, frontline providers in behavioral health agencies, primary care associations, and other relevant community support systems (e.g., places of worship, centers of aging, and fraternal organizations), and ethnic and racial-specific community providers and organizations.
6. In collaboration with individuals in recovery, peers, and family members, develop online curricula, Webinars, training tools, strategic planning guides, and other resources to assist States, Territories, Tribes, communities, and organizations adopt a recovery orientation

and/or further enhance their efforts to implement culturally competent recovery-oriented services and supports.

7. Promote individual recovery through safe and effective pharmacological/medication-assisted treatment for people recovering from substance use disorders when appropriate.

Objective 4.1.3: Engage individuals in recovery and their families in self-directed care, shared decisionmaking, and person-centered planning.

Action Steps:

1. Participate in HHS activities to develop cross-agency policies on participant-directed care.
2. Foster individual and family choice by supporting approaches in which service recipients choose behavioral health services and providers, such as voucher-based systems.
3. Develop and disseminate guides on person-centered planning for individuals, families, peers, providers, and administrators.
4. Provide information and assistance to States, Territories, Tribes, grantees, and provider organizations to design and implement self-directed care approaches and models, including targeted outreach to provider organizations serving diverse, underserved populations.
5. Work with the Centers for Medicaid and Medicare Services (CMS) and other Federal partners to develop and disseminate information and fact sheets on a range of recovery supports, including mutual aid associations and self-help groups, the faith community, transportation resources, dental care, housing and employment supports, education about self-care, the role of spirituality, the use of creative arts approaches, accessing recreational and other natural supports and social support opportunities available within communities, healthy and appropriate sexuality and relationships, the use of personal health records, and financial literacy for individuals with mental and substance use disorders.
6. Collaborate with policymakers and providers at State, Territorial, Tribal, and local levels in expanding programs that implement shared decisionmaking in behavioral health care.

Objective 4.1.4: Promote self-care and alternatives to traditional care.

Action Steps:

1. Collaborate with the National Institutes of Health (NIH) National Center for Complementary and Alternative Medicine in developing and disseminating information on complementary and alternative treatments and supports for individuals with mental and substance use disorders.
2. Publish and disseminate a guide for States, Territories, and Tribal nations on self-care approaches for individuals in recovery with mental and substance use disorders.

3. Work with the HHS initiative on multiple chronic conditions by having individuals in recovery with mental and substance use disorders delineate those self-care approaches that have been associated with decreased illness and death and enhanced wellness.

Goal 4.2: Home: Ensure that permanent housing and supportive services are available for individuals with or in recovery from mental and substance use disorders.

Objective 4.2.1: Improve access to mainstream benefits, housing assistance programs, and supportive services for people with mental and substance use disorders.

Action Steps:

1. Work with Federal partners to improve access to mainstream benefit programs and services (e.g., Medicaid, SSI/SSDI, Temporary Assistance for Needy Families, Special Needs Assistance Programs) by using demonstrated programs, including evidence-based enrollment strategies for Social Security Disability Insurance (SSDI); the Social Security Administration's Homeless Outreach Projects and Evaluation; U.S. Department of Housing and Urban Development (HUD) Housing Opportunities for People with AIDS, and online application software.
2. Work with Federal partners to develop policy guidance and directives that support recovery-oriented systems of care, provide integrated primary and behavioral health services, increase access to mainstream housing programs, and enhance the Nation's housing capacity for low-income individuals with behavioral health problems.
3. Distribute SAMHSA's Permanent Supportive Housing, Supportive Education, and Supportive Employment Toolkits, and related Treatment Improvement Protocols to Federal, State, Territorial, Tribal, and local partners; relevant professional and community-based organizations; and health care providers, especially those affiliated with behavioral health.
4. Disseminate information to behavioral health providers on effective financing strategies for creating and providing linkages to permanent housing and supportive behavioral health services using onsite and Web-based technical assistance as well as partnering with qualified Medicaid services providers, including Health Care for the Homeless organizations and federally qualified health centers (FQHCs).
5. Promote the use of evidence-based permanent housing and supportive services models in existing SAMHSA grant programs (e.g., Primary and Behavioral Health Care Integration, Access to Recovery, Pregnant and Post-partum Women, and Minority HIV/AIDS).
6. For those in recovery from substance use disorders, promote the use of evidence-based transitional drug-free housing, (such as peer-run, self-supported, drug-free homes, or community-based housing that includes a range of supportive services).

Objective 4.2.2: Build leadership, promote collaborations, and support the use of evidence-based practices related to permanent supportive housing for individuals and families who are homeless or at risk of homelessness and have mental and substance use disorders.

Action Steps:

1. Work in concert with the USICH (United States Interagency Council on Homelessness) and other Federal partners in implementing the Federal Strategic Plan to Prevent and End Homelessness, including a focus on populations especially vulnerable to homelessness (e.g., minorities, LGBTQ youth, and veterans).
2. Partner with HUD, the HHS Office of the Assistant Secretary for Planning and Evaluation, USICH, and other Federal partners to improve access to mainstream (e.g., housing choice vouchers) and targeted housing assistance programs (e.g., Veterans Affairs Supportive Housing) for individuals and families who are homeless and are experiencing behavioral health problems.
3. Work together with the Administration for Children and Families (ACF), CMS, Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), Indian Health Service (IHS), and HHS Office of the Secretary to streamline and coordinate technical assistance approaches aimed at preventing and ending homelessness, including a focus on diverse racial and sexual minority populations.
4. Improve health outcomes and access to care for people living with HIV/AIDS through stable housing and supportive behavioral health services.
5. Join forces with the Department of Veterans Affairs (VA) effort to end homelessness for the Nation's veterans through a memorandum of understanding and shared practices.
6. Collaborate with IHS to ensure that the specific needs of American Indians and Alaska Natives with behavioral health disorders are included in Administration efforts to prevent and end homelessness.
7. Collaborate with stakeholders (e.g., advocacy groups, nonprofits, foundations, businesses, and national minority and LGBT organizations) in efforts to increase recovery support services and housing opportunities for people who are homeless or at risk of being homeless upon leaving institutional settings, such as prisons, mental health facilities, and nursing homes.
8. Engage national experts to identify best practices related to permanent housing and recovery services for people with mental and substance use disorders, and to disseminate the findings to the field and inform the development of SAMHSA programs.

Objective 4.2.3: Increase the knowledge of the behavioral health field and SAMHSA grantees about housing and homelessness among people with mental and substance use disorders.

Action Steps:

1. Collaborate with Federal partners and other stakeholders to develop and disseminate a paper on a comprehensive housing and supportive services package based on evidence-based models and practices, including options for transition age youth.
2. Identify and take steps to address Federal, State, Territorial, Tribal, and local barriers to provide housing to individuals with substance use disorders and criminal records.
3. Use SAMHSA training, technical assistance, and Web technology resources and develop online curricula and other training materials focused on creating partnerships in local communities to prevent and end homelessness among individuals with mental and substance use disorders and educate the behavioral health workforce in identifying those at risk of homelessness as well as the supports and services that exist for individuals and families who are currently homeless.
4. Construct topic-specific community sites using SAMHSA's existing Web 2.0 technology to increase awareness of recovery-oriented systems of care, peer supports, and prevention of homelessness among behavioral health providers.
5. Increase knowledge among States, Territories, Tribes, provider organizations, and SAMHSA grantees about evidence-based interventions and recovery-oriented service systems aimed at preventing and ending homelessness for individuals with mental and/or substance use disorders.

Goal 4.3: Purpose: Increase gainful employment and educational opportunities, while decreasing legal and policy barriers, for individuals in recovery with mental and substance use disorders.

Objective 4.3.1. Increase the proportion of individuals with mental and/or substance use disorders who are gainfully employed and/or participating in self-directed educational endeavors.

Action Steps:

1. Convene stakeholders to develop a national strategic plan for identifying and addressing employment disparities among individuals with mental and/or substance use disorders.
2. Establish meaningful participation on SAMHSA's advisory councils by individuals in recovery from mental and/or substance use disorders and family members. When appropriate, convene subcommittees to address policy barriers to employment, especially for those with criminal justice histories.

3. Work with the Social Security Administration (SSA) in assisting individuals in recovery with mental and/or substance use disorders to use the Ticket to Work program.
4. Partner with the U.S. Department of Labor (DOL) to provide training and technical assistance to individuals in recovery from mental and/or substance use disorders by having a Toolkit to One-Stops, using the community recovery and resilience approach.

Objective 4.3.2. Develop employer strategies to address national employment and education disparities among people with and without identified behavioral health problems.

Action Steps:

1. Collaborate with Federal partners and other stakeholders in writing and disseminating a paper on a “Good and Modern Behavioral Health Employment Support System.”
2. Conduct a behavioral health awareness campaign focused on decreasing discrimination and improving employment outcomes for individuals with mental and substance use disorders.
3. Work with the National Business Group on Health to develop an employer’s guide to emotional wellness and drug-free workplaces.
4. Establish a SAMSHA workgroup to evaluate and provide guidance on best practices and strategies for including individuals in recovery in the workplace.

Objective 4.3.3. Improve the employment and educational outcomes among individuals with mental and/or substance use disorders served by SAMHSA grantees.

Action Steps:

1. Increase the use of funding that is or can be used by SAMHSA grantees or subrecipients to enhance supported employment, employment readiness and other vocational/employment supports, and education by individuals with identified behavioral health problems. Examples of SAMHSA grants include Mental Health Transformation Grants focused on supported employment, supported education, permanent supportive housing, and peer supports; Access to Recovery (ATR); Recovery Community Services Program; Targeted Capacity Expansion/Local Recovery-Oriented Systems of Care to continue providing employment-related services and supports, including peer-to-peer services, for people with behavioral health conditions and disorders; and Family-Centered Substance Use Treatment Grants for Adolescents and their Families.
2. Provide training and technical assistance on supported employment, permanent supportive housing, recovery housing, supported education, and recovery supports to relevant SAMHSA grantees or subrecipients.

3. Conduct Webinar seminar series in collaboration with SAMHSA's Office of Behavioral Health Equity to raise awareness of issues associated with employment and educational outcomes for diverse communities.

Objective 4.3.4. Implement evidence-based practices related to employment and education for individuals with mental and/or substance use disorders throughout all service systems.

Action Steps:

1. Work with Federal partners and the Mental Health Transformation Employment Work Group (FPEWG) to develop and disseminate a matrix for financing supported employment through Federal funding sources.
2. Work with the FPEWG and the Interagency Committee on Disability Research Subcommittee on Employment to market and disseminate supported employment and supported education toolkits to stakeholders providing employment supports to people with disabilities, including State offices of Vocational Rehabilitation, vocational rehabilitation service providers, DOL One-Stop Career Centers, SSA Employment Networks, independent living centers, U.S. Department of Veterans Affairs (VA) employment service providers, U.S. Department of Justice (DOJ) employment service providers, and educational and youth disability service organizations.
3. Develop and disseminate resources on peer-to-peer recovery support services related to job readiness, job skills training, vocational assessment, job preparation, and related skills for entering and remaining gainfully employed.

Goal 4.4: Community: Promote peer-support/mutual support and the social inclusion of individuals with or in recovery from mental and substance use disorders and their families.

Objective 4.4.1. Increase the number and quality of consumer/peer recovery support specialists and consumer-operated/peer-run recovery support service provider organizations.

Action Steps:

1. Work with CMS, other Federal and private sector partners to analyze frequency and service quality of claims data and information of the States, Territories, and Tribes to identify those that have used the option to offer peer support services as a component of a comprehensive mental health and substance use service delivery system in an effort to provide informed technical assistance and encourage expansion.
2. Develop and disseminate online tools and resources to assist peer-run and consumer-operated recovery support services organizations in assessing their readiness and enhancing their capacity to provide recovery support services for individuals with mental

and substance use disorders, including meeting relevant certification, licensure, and accreditation requirements. Expand the peer and consumer organizations to include those from diverse ethnic, racial, and sexual minority populations.

3. Convene stakeholder groups to develop a set of core competencies or standards for behavioral health peer-run/consumer-operated recovery support specialists and disseminate core competencies to appropriate agencies and policymakers, taking into consideration specific cultural competencies for diverse populations.
4. Provide training and technical assistance to States, Territories, Tribes, and localities on best practices for operating consumer-operated/peer-run recovery support services with consumer/peer/recovery organizations.
5. Leveraging the Statewide Family and Consumer Networks, provide training and technical assistance to grassroots peer-run and consumer-operated recovery support services organizations in areas including, but not limited to, organizational development, nonprofit management, community development, business practices, financing of services, respite programs, sustainability, leadership development, and recovery programming.
6. Collaborate with States, Territories, and Tribes to expand peer/recovery specialist approaches in criminal justice, homelessness, primary care, military families, HIV/AIDS, and other settings.

Objective 4.4.2: Promote the social inclusion of people with substance use and mental disorders.

Action Steps:

1. Protect the rights of individuals with mental and substance use disorders by providing assistance to State-designated protection and advocacy agencies.
2. Work with the HHS Community Living Initiative to foster the community integration of individuals with disabilities, including those with mental and substance use disorders.
3. Collaborate with DOJ and other relevant partners around compliance with and issues surrounding the Olmstead case.
4. Develop and disseminate training materials and provide other assistance to reduce the use of seclusion and restraint in all settings, including hospitals, correctional facilities, and educational institutions.
5. Provide information and assistance to States, Territories, Tribes, counties, organizations, and individuals on strategies that foster the social inclusion of people with mental and substance use disorders while acknowledging the social determinants of behavioral health problems, as described in *Healthy People 2020*.

Strategic Initiative #4 Measures

Population-Based

- Improve the health status of individuals with co-occurring physical and behavioral health conditions.

SAMHSA Specific

- Increase the percentage of individuals served by SAMHSA programs who have a positive perception of social connectedness to and support from others in the community, such as family, friends, coworkers, and classmates.
- Increase the number of States with reimbursement policies for services provided by certified peer support specialists to enhance the recovery and resiliency of others with severe emotional disorders, severe mental illness, and/or chronic substance abuse.

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