



**MEETING NOTICE
INVITATION TO NEGOTIATE COMMITTEE
WEDNESDAY, AUGUST 8, 2012
7:30 - 9:30 a.m.
COUNTY – CITY BUILDING – 555 S 10TH ST
ROOM 113**

AGENDA

1. Approval of Minutes - July 25, 2012
2. Consumer Input in Development of ITN
3. Draft ITN, Part Two

**MINUTES
COMMUNITY MENTAL HEALTH CENTER (CMHC)
INVITATION TO NEGOTIATE (ITN) COMMITTEE
WEDNESDAY, AUGUST 8, 2012
COUNTY-CITY BUILDING, ROOM 113
7:30 A.M.**

Committee Members Present: Ron Sorensen, Community Mental Health Center (CMHC); C.J. Johnson, Region V Systems; Judy Halstead, Lincoln-Lancaster County Health Department (LLCHD); Lori Seibel, Community Health Endowment (CHE); Captain Joe Wright, Lincoln Police Department (LPD); Brent Smoyer and Jane Raybould, County Commissioners; Gary Lorenzen, Mental Health Foundation; Gail Anderson, CMHC Advisory Committee; J Rock Johnson, consumer advocate; Vince Mejer, Purchasing Agent (Ex-Officio); Scott Etherton, CMHC (Ex-Officio); and Wendy Andorf, CMHC (Ex-Officio)

Committee Members Absent: Kerry Eagan, County Chief Administrative Officer (Ex-Officio)

Others Present: Alan Green, Executive Director, Mental Health Association of Nebraska (MHA-NE); and Ann Taylor, County Clerk's Office

Sorensen called the meeting to order at 7:35 a.m.

1 APPROVAL OF THE JULY 25, 2012 MINUTES

MOTION: J Rock Johnson moved and Wright seconded approval of the minutes. Sorensen, C.J. Johnson, Halstead, Seibel, Wright, Raybould, Lorenzen, J Rock Johnson voted aye. Smoyer and Anderson were absent from voting. Motion carried. Motion carried 8-0.

DRAFT INVITATION TO NEGOTIATE (ITN), SECOND VERSION

Sorensen clarified that there is not a new Invitation to Negotiate (ITN) draft. He noted the subcommittee met and discussed the process.

Anderson and Smoyer arrived at the meeting at 7:37 a.m.

Sorensen said providers and consumers will be involved in the process but that involvement will take place after approval of the process by the Region V Governing Board and County Board in September. Sorensen said the providers and consumers will be brought in to look at the service definition, expectations and model and be provided an opportunity to comment. He said interested parties will be identified through that process.

C.J. Johnson said they wanted to have a process to bring people together and get input regarding alternatives and to include those in considerations when entering into a request for proposal (RFP) situation. He added they don't necessarily want to get locked into competitive bidding.

Mejer said you want to have competitive negotiations and said it was his understanding that Region V would merge their documents with what the Committee had drafted into an ITN. Sorensen said that's correct and said that version will be brought back to the Committee for approval.

Raybould asked if the subcommittee developed a timeline for when that would be done. Sorensen said no timeline was set. C.J. Johnson said he believes it could be accomplished by the Committee's next meeting.

Seibel asked how the process will be communicated to providers. C.J. Johnson said through the County's website and mailing lists of providers.

Lorenzen asked how CMHC staff fit into the process. Sorensen said that will be addressed in the ITN document.

In response to a question from J Rock Johnson, Sorensen said the Region V Governing Board and County Board will be asked to approve the ITN document, which will include an outline of the process but not a service model.

Mejer suggested that a subcommittee run the ITN document by CMHC employees and get their input before making it public. Lorenzen concurred, stating they might identify something the Committee has missed.

J Rock Johnson suggested that the Committee also consider consumer involvement before the ITN document goes to the Region V Governing Board or County Board, as they also have specialized expertise. Mejer explained the document will be opened up to providers and consumers after it is approved by the two Boards.

Lorenzen noted that Dean Settle, former CMHC Executive Director, had expressed concerns regarding the transition of CMHC records to the new providers. Sorensen agreed that is an issue that will have to be addressed.

Seibel said there did not appear to be clear consensus in previous meetings on how to word the peer support and consumer run piece of the ITN. She asked that Anderson and J Rock Johnson, the consumer representatives, review the wording one last time before the document is finalized to see if it is satisfactory. J Rock Johnson said she has some suggestions she will forward to Sorensen.

J Rock Johnson also asked Sorensen to send out information on participatory dialogues, explaining it is a mechanism that has come out of the Substance Abuse and Mental Health Services Administration (SAMHSA) and is useful in having discussions with folks that have a differing viewpoint.

2 CONSUMER INPUT IN DEVELOPMENT OF THE INVITATION TO NEGOTIATE (ITN)

J Rock Johnson disseminated copies of standards and recommendations proposed by The Recovery Project of Lancaster County, Nebraska (Exhibit A). She said The Recovery Project is a group that started meeting several months ago in anticipation of having input into this process. J Rock Johnson said she believes it is a platform to begin to work with. She highlighted the following:

- Integration Steps (see Page 4)
 - Develop core values and principles based on input of consumers, providers, and stakeholders
 - Establish a conceptual framework based on this vision of recovery
 - Building workforce competencies and skills through training, education, and consultation
 - Changing programs and services structures
 - Aligning fiscal and administrative policies in support of recovery
 - Monitoring, evaluation and adjusting efforts
- Helping Consumers to Actively Participate (Page 6)
 - Arrange some type of financial compensation (per diems, expense reimbursements, wages, etc.) for consumers' time; they frequently live on very tight budget restrictions and want to be involved but the cost of participating prevents them from doing so

J Rock Johnson also referenced the sections titled Common Quality Indicators in Peer Recovery Support Services and Recovery Support Service Elements on Page 8. She noted SAMHSA has introduced recovery support services as part of the mental health block grant possibilities.

Raybould referenced the measurable outcomes cited on Page 4 and said she hopes the providers will also include consumer surveys. J Rock Johnson said the concept of measurable outcomes has not really been part of the service system. She felt it is critical on several levels: 1) System outcomes; 2) Individual outcomes; and 3) Provider outcomes. J Rock Johnson said problem solving and rights protection are key. She added that asking consumers to indicate satisfaction does not give actionable information.

Sorensen asked what the Committee wants to accomplish in terms of consumer input in terms of communicating and collecting information. J Rock Johnson said there isn't a

convenient way to access many of the consumers and get involvement and feedback. She suggested more planning and organizing are needed. Sorensen asked for ideas on how to accomplish that. Seibel asked J Rock Johnson whether she is referring to getting consumers involved in the ITN process or is she talking about something different. J Rock Johnson said all of that, including consumer involvement with the providers and services going forward. She said that has never been done before and said there is no infrastructure or models to follow. J Rock Johnson suggested searching for funding and a coordinator and developing a curriculum and opportunities for people to become involved.

Seibel asked Alan Green, Executive Director, Mental Health Association of Nebraska (MHA-NE), for his input. Green said he supports having the CMHC employees provide direct input before it goes to the Region V Governing Board and County Board. He added that the only "true expert" on whether services are effective is the person receiving the services and said he believes it would be beneficial to also have them provide input at that point. Green said the challenge will be to get consumers to come forward and said it may fall to consumer groups, MHA-NE and the National Alliance on Mental Illness (NAMI), to assist with that effort. He said what J Rock Johnson is suggesting is at the systems level and needs to be considered. Green said there definitely needs to be an educational component but suggested it may need to come at a later point. Anderson said she wants to see what providers "bring to the table" and then bring consumers in and ask for input. Sorensen noted that J Rock Johnson is part of the subcommittee that has worked on the ITN specifications and suggested it may be beneficial for Anderson to participate in that group, as well. Raybould suggested the Committee begin sending out "feelers" to those organizations and suggest a work session to explain the documents and open it up for discussion. J Rock Johnson said the CMHC consumers are not part of any organization. Anderson felt there needs to be a "cutoff", adding she does not see a point to repeatedly "going back" to the consumers if there is only limited participation. J Rock Johnson disagreed, stating she believes it is the Committee's responsibility to reach out to them.

Raybould exited the meeting at 8:24 a.m.

Lorenzen said he believes the handout is a good education tool of what a recovery-based model is and is something to aim for.

Halstead said she believes the Committee needs to move forward with getting the ITN out there, understanding that it won't be perfect and that adjustments can be made along the way.

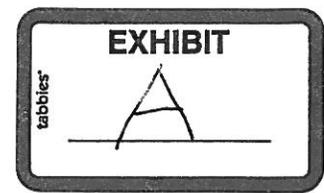
3 DRAFT INVITATION TO NEGOTIATE (ITN), SECOND VERSION

Item was moved forward on the agenda.

4 ADJOURNMENT

MOTION: Seibel moved and Smoyer seconded to adjourn the meeting at 8:32 a.m. Sorensen, C.J. Johnson, Halstead, Seibel, Wright, Smoyer, Lorenzen, Anderson, J Rock Johnson voted aye. Raybould was absent from voting. Motion carried 9-0.

Submitted by Ann Taylor, County Clerk's Office.



The Recovery Project of Lancaster Co NE Empowering & Amplifying Our Recovery Voice!

ITN Committee Recommendations: Standards and Recommendations for a Recovery-Based Integrated Service Model

Below you will find an outline of present standards and recommendations we found in practice throughout the nation. We found these particularly helpful in defining the national goals, the principles of recovery, the related recovery-based elements specific to a recovery-based service model, the specifics of recovery support services and engaging active consumer involvement. We hope this outlined material will be helpful and assist your model development.

1. Authority Sources

- a. Federal changes – New Freedom Commission on Mental Health: *Achieving the Promise: Transforming Mental Health Care in America* – Final Report – Executive Summary. DHHS Pub No. SMA-03-3832. Rockville, MD: 2003

1. Six Goals to Transform Mental Healthcare In America (pg 24-25 – Citation 1)

1. Understand that mental health is essential to overall health
 - a. Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention
 - b. Address mental health with the same urgency as physical health
2. Mental health care is consumer and family driven
 - a. Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
 - b. Involve consumers and families fully in orienting the mental health system toward recovery.
 - c. Align relevant Federal programs to improve access and accountability for mental health services
 - d. Create a Comprehensive State Mental Health Plan.
 - e. Protect and enhance the rights of people with mental illnesses.
3. Disparities in mental health services are eliminated
 - a. Improve access to quality care that is culturally competent.
 - b. Improve access to quality care in rural and geographically remote areas.
4. Early mental health screening, assessment, and referral to services become a common practice
 - a. Promote the mental health of young children.
 - b. Improve and expand school mental health programs.
 - c. Screen for co-occurring mental substance use disorders and link with integrated treatment strategies.
 - d. Screen for mental disorders in primary healthcare, across the life span, and connect to treatment and supports.
5. Excellent mental healthcare is delivered and research is accelerated.
 - a. Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses.

- b. Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.
 - c. Improve and expand the workforce providing evidence-based mental health services and supports.
 - d. Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.
6. Technology is used to access mental healthcare and information.
- a. Use health technology and telehealth to improve access and coordination of mental healthcare, especially for Americans in remote areas or in underserved populations.
 - b. Develop and implement integrated electronic health record and personal health information systems
- b. Quality Assurance Standards Applying to Primary and Behavioral Healthcare – National Committee for Quality Assurance (pg 7 – Citation 2)
- 1. Patient tracking and registry functions
 - 2. Use of non-physician staff for case management
 - 3. Adoption of evidence-based guidelines
 - 4. Patient self-management supports and tests (screenings)
 - 5. Referral tracking

2. Principles of Recovery

- a. Ten Rules for Recovery-Based Services (pg 2 – Citation 3)
- 1. Must be informed choice
 - 2. Must be recovery focused
 - 3. Must be person-centered
 - 4. Do no harm
 - 5. Must be free access to records
 - 6. Must be system based upon trust
 - 7. Must have focus on cultural values
 - 8. Must be knowledge-based
 - 9. Must be based on a partnership between consumer and provider
 - 10. Must have access to services regardless of ability to pay
- b. Principles of Recovery (pg 5 – Citation 4) (pg 1-2 – Citation 5)
- 1. Many pathways to recovery
 - 2. Self-directed and empowering
 - 3. Involves personal recognition of the need for change and transformation
 - 4. Is holistic, involving body, mind, relationships, and spirit
 - 5. Has cultural dimensions
 - 6. Exists on a continuum of improved health and wellness
 - 7. Emerges from hope and gratitude
 - 8. Is a process of healing and self-redefinition
 - 9. Involves addressing discrimination and transcending shame and stigma
- c. Principles of Recovery (pg 7 – Citation 4)
- 1. Person-centered
 - 2. Family & wellness supporter involvement
 - 3. Individualized and comprehensive services across lifespan
 - 4. Systems anchored within the community
 - 5. Continuity of care (pretreatment, treatment, continuing care, and recovery support)
 - 6. Partnership – consultant relationship focusing on collaboration and less on hierarchy
 - 7. Strengths-based (emphasis on individual strengths, assets, and resilience)

8. Culturally responsive
9. Responsive to personal belief systems
10. Commitment to peer recovery support services role
11. Inclusion of the voices of recovering individuals and their families
12. Integrated healthcare services (primary and behavioral)
13. System-wide education and training
14. Ongoing monitoring and outreach efforts
15. Outcomes driven
16. Based upon research
17. Adequately and flexibly financed

3. Essential Services in Recovery-Based Models

- a. Recovery-based model includes (pg 7 – Citation 5)
 1. Principles
 2. Values
 3. Service strategies
 4. Essential services

- b. Essential services defined (pg 161– Citation 6) (pg 11 – Citation 5)
 1. Treatment
 2. Crisis intervention
 3. Case management
 4. Rehabilitation
 5. Enrichment
 6. Rights protection
 7. Basic support
 8. Self-help
 9. Wellness / prevention

- c. Care Guidelines (pg 34 – Citation 7)
 1. Care is consumer and family-driven
 2. Care is timely and responsive
 3. Care is person-centered
 4. Care is effective, equitable and efficient
 5. Care is safe and trustworthy
 6. Care maximizes use of natural supports and settings

4. Characteristics of a Recovery-Based Model

- a. Characteristics defined (pg 164-165 – Citation 6) (pg 11 – Citation 5)
 1. Design
 2. Evaluation
 3. Leadership
 4. Management
 5. Integration
 6. Comprehensiveness
 7. Consumer involvement
 8. Cultural relevance
 9. Advocacy
 10. Training
 11. Funding
 12. Access

5. Continuity of Care

- a. Continuity of care defined (pg 25 – Citation 5)
 1. Pretreatment
 2. Treatment
 3. Continuing Care
 4. Rehabilitation
 5. Recovery support
 6. Offer a continuum of care
 7. Contributes to improved treatment outcomes

6. Measurable Outcomes

- a. Benchmarks of quality-of-life changes (pg 32 – Citation 5)
 1. Average time of first request by patient for service to first client treatment session
 2. Number of no-show patients not keeping appointments
 3. Admissions – number of unduplicated client admissions by provider
 4. Continuation – number of clients who stay engaged in treatment
- b. Measurable outcomes (pg 161 – Citation 6)
 1. Symptom relief
 2. Personal safety assured
 3. Services accessed
 4. Role functioning
 5. Self-development
 6. Equal opportunities
 7. Personal survival assured
 8. Empowerment
 9. Health status improved

7. Integration Steps

- a. CT Steps to Integrate Primary & Behavioral Healthcare (pg 34 – Citation 5) (pg 11 – Citation 4)
 1. Develop core values and principles based on input of consumers, providers, and stakeholders
 2. Establish a conceptual framework based on this vision of recovery
 3. Building workforce competencies and skills through training, education, and consultation
 4. Changing programs and services structures
 5. Aligning fiscal and administrative policies in support of recovery
 6. Monitoring, evaluation and adjusting efforts

8. Consumer Involvement Strategies

- a. Strategies for including Consumer involvement (pg 5 – Citation 8)
 1. Include consumers in mental health policies / planning activities
 2. Include consumers in mental health management / governance activities
 3. Include consumers in mental health service delivery activities
 4. Include consumers in mental health training program development and activities
 5. Actively promote consumer-operated programs and services
- b. Other consumer involvement strategies gleaned from all research materials to date:
 1. Identify roles for consumers / families

1. Identify ways that consumers and families can play an active role in the determination of mental health policies and issue a policy recognizing and supporting the importance of active consumer involvement in all aspects of mental health service planning and delivery
2. Engage consumers and families in all planning and policy making bodies at state, regional, and local levels. Involve them in evaluation activities, new program development, grant writing, etc.
2. Peer Program Development and Operations
 1. Assist with engaging consumers in planning and developing Peer-Operated / Peer-Run programs
 2. Provision of consumer guidance in initially operating Peer-Operated / Peer-Run programs
3. Peer Staffing Supports
 1. Engage and assist consumers in coordinating and developing Peer Support Specialists, Peer Mentoring / Peer Coaching, BH Peer Navigators and any related credentialing requirements
 2. Employ consumers, provide training and supports to provide emergency and social support programs, case management, and office support staff
4. Oversight / Governance Panels
 1. Create a Consumer Oversight Panel / Committee to monitor, evaluate, resolve consumer complaints with the new service providers
 2. Create an Office of Consumer Affairs – to serve as a watchdog agency and an in-house advocacy capacity for consumers; with a clear grievance process
5. Advisory Panels / Board Service / Taskforces/ Evaluation Committees
 1. Create and develop Consumer Advisory Panels to actively engage with new service providers and regional / state behavioral health authorities
 2. Create a Consumer Council with direct contact to system leadership for input on policies and practices; engage state attention to services, training and support needs
 3. Consumers and family members can serve on boards, taskforces, study groups, evaluation committees, advocacy / advisory committees, and consumer preference studies
6. Advocacy / Ombudsman
 1. Develop a Consumer Ombudsman / Advocate to assist with development of:
 - a. Ethical codes / standards for peer programs, peer specialists, peer coaches, and other recovery support services
 - b. Advocacy for all consumers
 2. Uniform complaint system developed
 3. Rights protection for consumers
7. Administrative Services
 1. Consumers can provide administrative services i.e.:
 - a. Handouts
 - b. Mailing announcements
 - c. Copying

- d. Reminder phone calls
- e. Stuffing conference packets
- f. Staffing registration tables
- g. Distributing evaluation forms,
- h. Conducting survey's and analysis

8. Support Services

- 1. Consumers can create alternatives via preference surveys, focus groups, public hearings, written surveys for:
 - a. Safe house
 - b. Drop-in centers
 - c. Hotlines; warm lines
 - d. Peer support groups
 - e. Housing referrals
 - f. Case management functions
 - g. Other peer programs

9. Peer Recovery Support Services

- 1. Develop Peer-to-Peer Support Services either as a committee, or as strategic partnerships with mental health agencies / new service providers
- 2. Consumers can offer free-standing support groups

c. Helping consumers to actively participate

- 1. Arrange for transport assistance, rides to/from meetings when consumers have difficulty with transport issues
- 2. Arrange some type of financial compensation (per diems, expense reimbursements, wages, etc) for consumer's time; they frequently live on very tight budget restrictions and want to be involved but the cost of participating prevents them from doing so
- 3. Arrange for some type of non-financial compensation legally allowed
- 4. Extensive public communication plan to notify all consumers of the opportunities to get involved at various levels (i.e. consumer open houses, Consumer/Family Coalition meetings, Recovery Project meetings, print ads, radio ads, flyers/handouts, distribution of flyers to local business frequented by consumers, etc.)
- 5. Establishing regular meetings or lunch meetings with consumers and family members to identify current issues and concerns and conduct follow-up inquiries

9. Peer-Operated / Peer-Run Programs

a. Strategies for peer-operated/peer-run programs (pg 5 – Citation 8)

- 1. Safe houses
- 2. Drop-in centers
- 3. Hotlines
- 4. Warm lines
- 5. Peer support groups
- 6. Housing referral services
- 7. Advocacy programs (state, regional, or local)
- 8. Recovery support services programs

b. Peer Mentoring / Peer Coaching - Critical Training Criteria (pg 83 – Citation 9)

- 1. Role expectations
- 2. Mentoring examples
- 3. Relationship building

4. Self-care
5. Barriers
6. Confidentiality
7. Avoidance of personal relationships
8. Identification of community resources
9. Successful networking strategies

10. Recovery Support Services

- a. Recovery Support Services defined (pg 7 – Citation 4)
 1. Person-centered
 2. Family & wellness supporter involvement
 3. Individualized and comprehensive services across lifespan
 4. Systems anchored within the community
 5. Continuity of care (pretreatment, treatment, continuing care, and recovery support)
 6. Partnership – consultant relationship focusing on collaboration and less on hierarchy
 7. Strengths-based (emphasis on individual strengths, assets, and resilience)
 8. Culturally responsive
 9. Responsive to personal belief systems
 10. Commitment to peer recovery support services role
 11. Inclusion of the voices of recovering individuals and their families
 12. Integrated healthcare services (primary and behavioral)
 13. System-wide education and training
 14. Ongoing monitoring and outreach efforts
 15. Outcomes driven
 16. Based upon research
 17. Adequately and flexibly financed
- b. Individualized Recovery Planning (pg 12 – Citation 4)
 1. Service is individualized
 2. Multidisciplinary recovery plan developed with the person receiving the services they identify as needing
 3. The recovery plan includes:
 1. The person's hopes, assets, strengths, interest, and goals
 2. It reflects a holistic understanding of behavioral health concerns, medical concerns, and a desire to build a meaningful life in the community
- c. Recovery Support Services Programs – SAMHSA Service Definitions
 1. Self-Directed Care – Service Definition (Citation 10)
 2. Behavioral Health Peer Navigator – Service Definition (Citation 11)
 3. Peer-Operated Recovery Community Centers – Service Definition (Citation 12)
 4. Peer Recovery Support Coaching – Service Definition (Citation 13)
 5. Relapse Prevention / Wellness Recovery Support – Service Definition (Citation 14)
- d. Four Types of Recovery Support Services (pg 9 – Citation 4)
 1. Emotional – empathy, caring, concern
 2. Informational – education, skills, wellness information, voting rights or other citizenship restoration, etc.
 3. Instrumental – assistance with task accomplishment (i.e. connections to referral agencies, food banks, vocational rehabilitation, childcare, transportation, driver's license, etc.)

4. Affiliation – assistance with connecting with social organizations or social settings

e. Common Quality Indicators in Peer Recovery Support Services (pg 18 – Citation 4)

1. Clearly defined recovery support services that differentiate them both from professional and sponsorship treatment services
2. Programs / services that are authentically peer in design and operation
3. Well-delineated processes for engaging and retaining a pool of peer leaders
4. Intentional focus on leadership development for peer leaders
5. Operates within an ethical framework that reflects peer and recovery values
6. Incorporates principles of self-care and a well-considered process for handling relapse of peer leaders
7. Services that are non-stigmatizing, inclusive, and strengths-based
8. Honors the cultural practices and incorporates cultural strengths into the recovery process
9. Connects peers with other community resources
10. Well-established, mutually supportive relationships with key stakeholders
11. Has a plan to sustain itself
12. Well-documented governance, fiscal, and risk management practices to support its efforts

f. Recovery support service elements (pg 8 – Citation 4)

1. Employment services and job training
2. Case management and individual service coordination (i.e. referrals)
3. Outreach
4. Relapse prevention
5. Housing assistance and services
6. Childcare
7. Transportation to/from treatment, recovery support activities, employment, etc.
8. Peer-to-peer services, mentoring, and coaching
9. Self-help and support groups
10. Life skills
11. Substance abuse education
12. Education
13. Parent education and child development support services
14. Spiritual and faith-based support
15. Family / marriage education

Reference Citations

Citation

- 1 New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America* – Final Report – Executive Summary. DHHS Pub No. SMA-03-3831. Rockville, MD: 2003
[http://govinfo/library.unt.edu/mentalhealthcommison/reports/FinalReport/downloads/FinalReport.pdf](http://govinfo.library.unt.edu/mentalhealthcommison/reports/FinalReport/downloads/FinalReport.pdf)
- 2 Milbank Memorial Fund: *Evolving Models of Behavioral Health Integration in Primary Care* – 2010. Collins, Hewson, Munger, and Wade
- 3 *Infusing Recovery-Based Principles into Mental Health Services* – A White Paper by People who are NY State Consumers, Survivors, and Patients & Ex-Patients – Sept 2004
www.recoveryxchange.org/downloads/whitepaper.pdf
- 4 *The Role of Recovery Support Services in Recovery-Oriented Systems of Care* – Kaplan, L. - DHHS Pub No SMA-08-4315. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration (SAMHSA), 2008
www.facesandvoicesofrecovery.org/pdf/SAMHSARecoveryWhitePaper.pdf
- 5 *Guiding Principles & Elements of Recovery-Oriented Systems of Care: What do we know from the research* – August 2009 – USDHHS – SAMHSA
http://partnersforrecovery.samhsa.gov/docs/guiding_principles_whitepaper.pdf
- 6 *A Recovery-Oriented Service System: Setting some System Level Standards* – Fall 2000. Wm A. Anthony, Exec Director – Center for Psychiatric Rehabilitation at Boston University
www.bu.edu/cpr/repository/articles/pdf/anthony2000.pdf
- 7 *Practice Guidelines for Recovery-Oriented Care for Mental Health & Substance Use Conditions* – 2008 – CT Dept of health & Addiction Services – Second Edition – 12/2008 www.ct.gov/dmhas/publications
- 8 *Strategies for Increasing & Supporting Consumer Involvement in Mental Health Policy / Planning, Management & Services Delivery* – NASMHPD Position Paper 12/89
- 9 *Shared Decision-Making in Mental Healthcare; Practice, Research, & Future Directions*. HHS Pub No. SMA-09-4371. Rockville, MD: Center for Mental Health Services, Substance Abuses & Mental Health Administration – 2010 www.samhsa.gov/shin
- 10 *Self-Directed Care Service Definition* – Recovery Support Services 5/9/11– SAMHSA Center for Financing Excellence [www.samhsa.gov/grants/blockgrant/Self Directed Care Service Definition 05-09-11.pdf](http://www.samhsa.gov/grants/blockgrant/Self_Directed_Care_Service_Definition_05-09-11.pdf)
- 11 *Behavioral Health Peer Navigator Service Definition* – Recovery Support Services 5/6/11 – SAMHSA Center for Financing Excellence [www.samhsa.gov/grants/blockgrant/BH Peer Navigator 05-06-11.pdf](http://www.samhsa.gov/grants/blockgrant/BH_Peer_Navigator_05-06-11.pdf)

- 12 *Peer-Operated Recovery Community Center Service Definition* – Recovery Support Services 5/6/11 – SAMHSA Center for Financing Excellence
www.samhsa.gov/grants/blockgrant/Peer_Operated_Recovery_Center_Services_05-06-11.pdf
- 13 *Peer Recovery Support Coaching Service Definition* – Recovery Support Services 5/12/11 – SAMHSA Center for Financing Excellence
www.samhsa.gov/grants/blockgrant/Peer_Recovery_Support_Coaching_Definition_05-12-11.pdf
- 14 *Relapse Prevention / Wellness Recovery Support Service Definition* – Recovery Support Services 5/12/11 – SAMHSA Center for Financing Excellence
www.samhsa.gov/grants/blockgrant/Relapse_Prevention_Wellness_Recovery_Support_Definition_05-12-11.pdf