Interview #11 Dr H. Westley Clark - Reflections on the Historic 2001 Recovery Summit in Saint Paul, Minnesota, and the Start of the New Recovery Advocacy Movement

Forward: I first met Dr. H. Westley Clark. MD, JD around the year 2000, when I heard him speak at an event in Philadelphia. He has had such a huge positive influence in his work to move our SUD care system towards a recovery focus. He is still very active in the field in his current position as the Dean's Executive Professor of Public Health at Santa Clara University in Santa Clara California. At the time he spoke back in 2000, he was the Director of the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Service, where he led the agency's national effort to provide effective and accessible treatment to all Americans with addictive disorders. His Curriculum Vitae is among the nation's most impressive. I have listed a portion of his professional life accomplishments in the paragraphs below.

Beyond his extensive achievements, one of our areas of common interest and collaboration has been around federal SUD privacy laws and the importance of those laws and the accompany regulations to assure that people like us who experience a substance use disorder can get help without fear of consequences. Over the years he took time to show and teach me some of the nuances of these laws and regulations. He helped author the law 42 U.S.C. § 290dd-2 that answered the first question I asked when I walked into a treatment center in 1986. I needed to know what happens to the information I had to share to get well because drug use is illegal. He made sure that information was protected. His work in this area assured that the question could be answered in a way that made me feel safe enough to talk with the people trying to help me. Over the years, he has served as a mentor to me in respect to substance use privacy laws and regulations, he is a huge resource on this and many other areas. His mentorship has helped many of us and extend these protections to ensure the next generation can also be assured that their privacy rights are also protected.

In the course of our interview, I asked Dr Clark why he cared about those who have experience substance use issues so much. He reminded me of the start of his career, working in the Haight Ashbury section of San Francisco with Dr David Smith in the mid-1980s, he talked about his work with Methadone and being the medical director of clinics in several areas of the country and all he has done in his 75 years. The truth is that many others see what he saw in respect to the consequences of addiction, and they move on to a less stigmatized issue. He did not. He saw us, he saw our plight and he saw our resiliency and potential and he dedicated his professional life to working on our issues. Issues which have always been so highly charged with stigma and discrimination. It was apparent to me that the idea of not helping simply never occurred to him. I told him that beyond all of his academic and other significant life achievements, one of the things that made him such an exceptional human being is he really saw us – people with substance use issues. He committed to working with us and helping us over the course of his entire career. Unfortunately, people who see us and engage with us from a perspective of positive regard and collaboration remains more of an exception rather than the rule. The kind of commitment he has to our community is exceptional and is to be honored and acknowledged. We could use many more people like Dr H. Westley Clark.

Prior to directing CSAT, Dr. Clark was the former chief of the Associated Substance Abuse Programs at the U.S. Department of Veterans Affairs Medical Center in San Francisco, California and a former associate clinical professor, Department of Psychiatry, University of California at San Francisco (UCSF). Dr. Clark served as a senior program consultant to the Robert Wood Johnson, Substance Abuse Policy Program, a co-investigator on a number of the NIDA

funded research grants. He worked for Senator Edward Kennedy as a health counsel on the US Senate Committee of Labor and Human Resources. A more complete bio is here.

1. Who role did you have in helping ensure there was a Recovery Summit in 2001 in Saint Paul?

What we did preceded the recovery summit and starts with the Recovery Community Service Project, that was a priority of ours when I lead SAMHSA. This was an issue I cared a lot about and worked hard with others like Cathy Nugent to create. In the preceding years we started to become quite aware that we needed to have more than what could be offered in a traditional acute care treatment service model. The acute care model was just not cutting it. To do this, we needed to bring the resources of the recovery community into the picture. This has both service and broad advocacy dimensions. It was clear to us that we needed to invest more in long term support efforts and community strengthening efforts. So, we made it a priority.

I am sure that my experience working as a physician in the treatment space informed my own perspective. What do people do to support their recovery when the treatment center is closed? My office hours end at 5 PM, what do my patients have for support at 6 PM? What kind of support was available for families? What do people do on the weekends to support their healing?

I had seen the power of recovery and what one person in recovery helping another had the potential to really change things if we funded it. With my work the Veterans groups I saw the value of one vet helping another vet. A similar model and advocacy dynamic has also unfolded in respect to HIV and the gay community organizing to help each other and to assert their basic rights. I realized that some of these very same dynamics could be leveraged to save a lot of lives in relation to substance use.

We also knew that public attitudes about addiction and recovery were not great. From a BIPOC perspective, we can say that there is a whole lot of hostility towards people experiencing addiction, with some groups experiencing more hostility that others. We have made some progress, but this is still the case today – there is a lot more to do to support recovery. At the time, we also knew that we needed to elevate voices of recovery and have the larger society see what people in recovery have to contribute, which is substantial. So we started the Recovery Community Support Project, which eventually became the Recovery Community Services Project because of some political considerations as federal administrations changed. We knew that starting the RCSP would mean that the Saint Paul Recovery Summit would be a natural outcome. It is a relatively small community; a lot of people were seeing the direction we needed to go and were willing to work together to make it happen. The work that SAMHSA did with its relatively modest levels of funding played a significant role in what transpired.

2. What do you see that came out of your efforts at the time around the RCSP and the Recovery Summit?

We initiated a change in the sociological and philosophical view of addiction by emphasizing recovery! It is important to note that not all jurisdictions have or are necessarily supportive of recovery community organizations. We saw recovery as an organizing concept as I spoke about in this interview with Bill White back in 2007. This was true then and it is still true today. Changing these attitudes and making sure that recovery is seen as viable and supported is important for all of our communities. Our efforts at SAMHSA and what transpired at the recovery summit has served as a springboard to changing these attitudes and ensuring that recovery support and recovery community are prevalent across America. It is also important to note we achieved what we have with a relative meager amount of dollars, to accomplish more it has to be valued and it has to be funded. Take drug court funding as an example. They were getting 70 million when recovery was getting a fraction of that. Nothing against drug courts, it just shows the difference of priority, and we must value recovery and fund it in ways that get resources to our grassroot communities as this is where the work is being done!

We had people like Tom Kirk, Jr PhD, do tremendous things to build out recovery care systems. Although we lost Tom in 2020 he did so much to bring recovery efforts in communities to the forefront. Tom was the former Commissioner of the Connecticut Department of Mental Health & Addiction Services whose leadership transformed Connecticut's mental health system and recovery efforts across the state. He was a pioneer in moving that system to a recovery-oriented system of care model and his influence was felt in the work we were doing. There were other people like Tom who were

raising up the value of recovery and the power of recovery community in ways that helped, along with the writings of Bill White on recovery management to synthesize additional actions.

We also have not had benefactors like the large pharmaceutical companies funding MAT outreach efforts. What we have had instead is a motivated community that at the time was largely abstinence focused, but we helped widen that lens by emphasizing many pathways to recovery, which has led to a much broader sense of recovery as a result. Beyond that, we also stimulated the discussions that led to the creation of Faces & Voices of Recovery. If you think about it, a whole lot was accomplished with the meager resources available, and this is in part because what we were doing resonated with so many people in so many communities across America.

3. What are you most proud of in respect to what was accomplished?

We grew something and allocating funds to recovery was a critical element. What was done helped stimulate a dialogue that has continued through present times. We helped show America that there were care models and supports that extended beyond the acute care models into our communities. Unless you were wealthy, short-term care is pretty much the only thing that was available before then, there were no community supports! The early efforts to bring recovery organizations together was mostly focused on abstinence-based models of recovery, but we were very cognizant that it was important to emphasize many pathways to recovery.

The work we did at SAMHSA went a long way to set the stage to change the dialogue by focusing on recovery. It was well worth the investment. What was very clear to me from my life experience as the medical director of programs in Michigan and Massachusetts and beyond is that we needed support for the holistic needs of all of these communities, including those using MAT pathways. My work in San Francisco helped prepare me for the opioid epidemic because we saw what happened there in that era, but we learned through things like the free clinic model to care for people as the focus of the work. We still somehow miss this as the core of what we need to focus on, even decades later.

Peer services in grassroots recovery community organizations are an integral element of a care system that meets people needs. We need to serve people with dignity and respect and offer assistance in ways that support their wellness, not just for a single substance or for an acute care episode but in ways that help them sustain growth in all life domaines over the longer term. Our efforts back then were fundamental to moving dialogue in the direction and to support these needs and beginning to value people who advocate for access to services that support their wellness in their communities.

4. What did we miss if anything looking back at what you set out to accomplish?

I don't think it is a fair question on some level. What was done was done by people operating on shoestring budgets. I don't think we missed a thing. If we had more resources, we would have been able to accomplish more. We brought people together, we started recovery month, which is now celebrated around the country. We helped develop ways for people to talk about recovery and do outreach that had very positive ramifications. Recovery became visible and that began to change perceptions about what addiction looks like and more importantly, what recovery looks like.

There is certainly more work to be done. We need to have discussions about what happens when there is a resumption of use, how we connect families to support and a myriad of other things. We have to avoid the trap of focusing on a single facet of addiction. COVID-19 is a perfect example. People are under stress, their kids are under stress, their partners are under stress. They are worried about their economic situation, and they are more isolated from others than they were in pre-covid times. It is fair to say we will see increases in alcohol and other drug use and there will be consequences for using these drugs to cope that will last a long time. But we must stop making the mistake of focusing on the drug as the primary area of concern. Let's focus on healing, let's focus on the person, lets focus on their children and their family, lets focus on the community! We cannot forget housing, employment, health and mental health; all of these contribute to the well being and dignity of a person.

We should ask how we can help people cope with what they are going through and meet them where they are with tools to help them heal in a more effective way. This is more than a harm reduction model; it is a recovery model. It is what we

need to continue building out. But the lesson from what we did was not what we missed; the lesson is that we can accomplish so much more. We could expand recovery communities on the ground and connect them with the rest of our care system to support the needs of people in diverse communities across America. What can we do to help you cope and connect with support that work for you? This is a recovery orientation, and the recovery community has a tremendous amount to offer that would help us address these challenges, that is if we allocate funds and support the development of infrastructure inclusive of diverse recovery communities.

The historic recovery set aside effort underway in DC and ensuring that we have a permanent way to fund recovery support is a prime example of the ongoing nature of this work and our forward momentum. We do what we can do to make it happen on Monday and if on Tuesday we have not accomplished our goal it is what we work on when we get out of bed on Wednesday. We just simply keep at it. Perhaps this is what a summit now should focus on now, ensuring this agenda gets done and that people in recovery are at every table. The "nothing about us without us" focus to ensure people in recovery are at the table in a meaningful way and not ever giving up until that is a reality. It looks like a worthy focus to me.

5. What are you most concerned about in respect to the future?

We need to make sure resources get to the communities and not get preempted by other agendas. We are currently in a topography of change. So much is going on with syndemics, pandemics and epidemics. Unfortunately, much of the treatment system is rife with fraud and we must deal with that. Parity was codified into law, but enforcement policies are not being executed. There is great promise in harm reduction efforts but some of what is happening in that space is sensitive politically. Prevention is challenged to show outcomes on how it promotes lifestyles that reduce drug use and recovery efforts remain on a shoestring and at times are not being used in ways that are as helpful as they could be. There are plenty of challenges, but there have always been challenges. What we helped set up a is a community structure that can help us address these needs and move care and support in ways that work better and are run more effectively.

6. What would you say to future generations of recovery advocates about what we did and what to be cautious of / your wishes for them moving forward?

We must ensure we have a robust recovery safety net for people who experience a substance use issue. We need to make sure we offer people social and psychological support that meets their needs no matter what community they live in. We need to watch out for opportunists who take advantage of vulnerable people. Opportunists have always been present in the background, and we need to keep an ever-watchful eye out for them. We must be cautious of the forces of greed, avarice, and fraud. A lot of people get taken advantage of when they are seen as the means to make a quick buck rather than a member of a community worthy of serving. People with addictions are seen as vulnerable and to be exploited and we need to be ever present in our guard against such things. The twelve step communities dealt with this in terms of thirteen steppers – people taking advantage of the vulnerable newcomer. We need to focus here and set up ways to ensure proper care and support that is ethically provided in a transparent way informed by the experts on recovery – people in recovery.

These trends are not new. I see groups like Faces & Voices doing constructive things to operationalize recovery support and to set up standards of conduct and ethical frameworks to operate from. These are important areas of focus, and I would tell them to pursue progress with an eye towards on ethics. To consider how they do things in ways that support the whole community and guard against those who take advantage of others for personal gain.

I think what we did back then makes evident now what could be accomplished if we more fully embrace a model of sustained recovery management that is developed for and by our grassroots recovery communities. Our work on the RCSP initiatives and what happened at that historic recovery summit in 2001 demonstrated that there are vast, untapped, and underutilized resources in our communities. It is something I have seen over the course of my own career, and I know that if future advocates work to bring these communities together in ways that validate the resiliency and power of recovery to change lives and communities, it will fundamentally change our care system and save millions of lives.

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