Enhancing Community Recovery Capital in America:

Recovery Support Service Models, Efficacy, and Financing

"The community is the soil in which alcohol and other drug problems grow or fail to grow and in which the resolutions to such problems thrive or fail to thrive over time."

– William L. White, Emeritus Senior Research Consultant, Chestnut Health Systems

THIRD HORIZON
STRATEGIES

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RECOVERY CAPITALIZATION

Despite significant policy and public attention on the opioid epidemic in recent years, in 2020 over 93,000 Americans died from drug overdoses.[1] Daily, there are 128 opioid-related deaths[2] and 261 alcohol-related deaths.[3] However, 89 percent of those 12 and older who need addiction treatment and recovery support services don't receive it.[4] This treatment gap – which arguably represents the largest health inequity of any major health challenge in the United States – requires bold new "upstream" and "downstream" investments that will leverage and exponentially scale the impact of recent addiction treatment expansion initiatives underway in Medicaid, commercial insurance, and a variety of federal and state discretionary grant programs.

It is imperative that our addiction crisis response evolves from an acute, short-term, individual-focused treatment response to a broader, community, long-term recovery response. Addiction is a chronic illness, and recovery is a life-long process where external community and social determinants of health play a vital role in its sustainability. The United States Surgeon General's 2016 seminal report *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs and Health* focused an entire chapter (chapter 5) on recovery, asserting that it takes five years of sustained substance problem resolution before individuals reach the point of recovery stability in which risk of a future substance use disorder (SUD) recurrence equals the SUD risk within the general population.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), "the process of recovery is highly personal and occurs via many pathways... The process of recovery is supported through relationships and social networks... Recovery services and supports must be flexible. SAMHSA established recovery support systems to promote partnering with people in recovery from mental and substance use disorders and their family members to guide the behavioral health system and promote individual, program, and system-level approaches that foster health and resilience; increase housing to support recovery; reduce barriers to employment, education, and other life goals; and secure necessary social supports in their chosen community."[5]

To achieve measurable results and dramatically improve recovery outcomes over a longitudinal period for an individual, the United States must begin to dedicate funding to the underlying community conditions. Recovery capital—both its quantity and quality—plays a major role in determining the success or failure of recovery.[6] Recovery support programs provide community-level resources for people with an SUD beyond primary prevention and clinical treatment.

EXISTING FEDERAL PROGRAMS AND RECOVERY SUPPORT SERVICES

The federal government dedicates nearly $500 million annually for primary prevention strategies via the Substance Abuse Block Grant (SABG) and provides tens of billions of dollars for clinical addiction treatment services though other grant programs and Medicaid. The addiction treatment funds are "eligible" to be spent on non-clinical recovery-oriented supports. Each state's Single State Authority (SSA) determines how to allocate the funds and distinguishes between treatment and recovery support. These individual interpretations have caused a woefully underfunded organized recovery community of just 150 local communities with mostly small and fledgling Recovery Community Organizations (RCOs).

Figure 1: Extending Social Determinants of Health to Include Recovery Asset Capitalization

ECONOMIC STABILITY	EDUCATION	HEALTH AND HEALTH CARE	NEIGHBORHOOD AND BUILT ENVIRONMENT	SOCIAL AND COMMUNITY CONTEXT
HEALTHY OUTCOMES				
Poverty Employment Opportunities Food Insecurity Housing Instability	Early Childhood Education and Development High School Graduation Enrollment in Higher Education Language and Literacy	Access to Health Care Access to Primary Care Health Literacy	Access to Foods that Support Healthy Eating Patterns Quality of Housing Crime and Violence Environmental Conditions	Social Cohesion Civic Participation Discrimination Incarceration
RECOVERY CAPITALIZATION				
Life and job skill training Re-entry support services Legal services	Recovery High Schools Collegiate Recovery Programs Recovery support services in secondary education	MH/SUD Assessment and Treatment Counseling and addiction professionals Care coordination and contingency management	Prevention and harm reduction services Recovery and transitional housing Access to alcohol-free stores and restaurants	Recovery and mental health treatment courts Peer recovery support Recovery Community Organizations Mutual aid support meetings

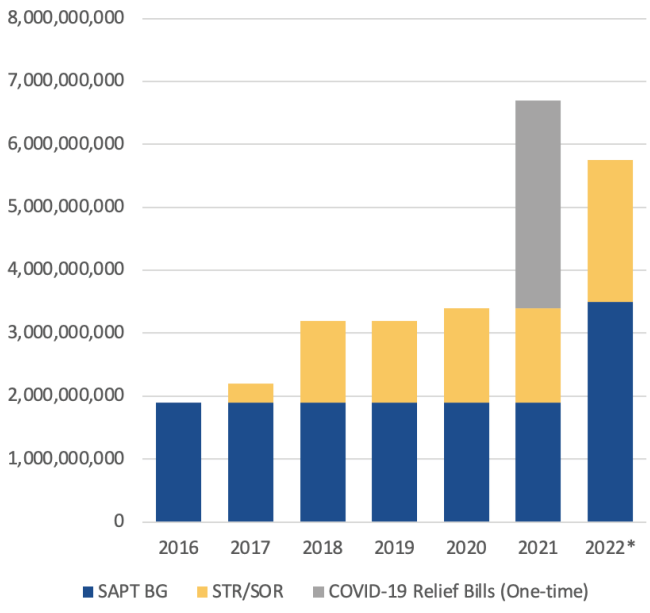
Source: sr4-DIS created this image using the five social determinants of health topics outlined in Healthy People 2020

Grassroots community RCOs essentially don't receive any dedicated funding – federal or philanthropic – to develop and cultivate sustainable and cyclical recovery capital in local communities. President Joe Biden's FY 2022 budget proposed a $1.65 billion funding increase in federal SABG dollars to states, including a new 10 percent Recovery Support Set-Aside for recovery support services (Figure 2).

"This funding set-aside would provide a sustainable source of funding directly to community organizations to support development of a community level recovery infrastructure and will be available for a wide variety of recovery support programs."

– SAMHSA FY2022 Budget Summary

Figure 2: Recent History of Primary Federal Funding Programs Provided to SSAs To Address SUD/OUD



*Presidential Budget Request

Federal Program Recovery Support History

SAMHSA has been instrumental in setting the stage for the emergence of the organized recovery community and its role in developing recovery-oriented systems of care, as well as peer and other recovery support services. In 1998, the agency initiated the Recovery Community Support Program (RCSP) to help the recovery community organize members to participate in public policy discussions and to develop campaigns to combat stigma.[7] In 2003, SAMHSA changed the name to the Recovery Community Services Program (RCSP) and began providing funding for grantees to develop and provide innovative, peer-based recovery support services in community settings. Private and public payers across health care now leverage many of these innovations. A short video on the history of RCSP can be viewed here.

In 2004, the Bush administration introduced Access to Recovery – a presidential initiative that created a voucher system that gives clients a choice of eligible treatment providers from which to obtain needed recovery services. That same year, SAMHSA awarded the first Access to Recovery grants to 14 states and one Indian Health Board. The funding required grantees to maintain a diverse network of community and faith-based organizations that offer treatment and recovery support services for the full three-year performance period. SAMHSA awarded second-round grants in 2007.

These innovative federal programs were the forerunners to several other small grant initiatives that support recovery, such as Targeted Capacity Expansion grants for Recovery-Oriented Systems of Care, Peer-to-Peer programs, and Budling Communities of Recovery. The Obama administration utilized some of these learnings as part of the large State-Targeted Opioid Response grants, which provided funding that allowed many states to expand their opioid use disorder recovery funding, under the CURES Act. While similar state-focused opioid programs continued during the Trump administration, ofttimes states used the funds to scale clinical addiction treatment services rather than investing in the infrastructure needed to scale the organized recovery community and extend the outcomes of many of the clinical investments.[8]

The following sections of this paper will provide a snapshot of emerging and promising data surfacing from diverse recovery support services. SAMHSA's Peer Recovery Center of Excellence published an additional peer recovery support reference which can be found online at peerrecoverynow.org.

RECOVERY COMMUNITY CENTERS

Background

Recovery community centers (RCCs) fulfill an important role in active recovery, helping individuals build relationships and recovery supports that are necessary to maintain recovery. Importantly, RCCs are often run by paid directors with support from volunteers and are not sober living homes, but centers where individuals are able to build recovery capital.[9] RCCs may also connect individuals with key social services, including assistance with obtaining work.

The Association of Recovery Community Organizations (ARCO) at Faces & Voices of Recovery is a membership program that unites and supports the growing network of local, regional, and statewide Recovery Community Organizations (RCOs) through networking opportunities and sharing resources.

Functions / Services Delivered

RCCs provide numerous services, including recovery coaching, recovery information and

resource mobilization, mutual-help and peer-support organization meetings, social activities, and training.[10] Although RCCs provide different services depending on an array of factors, a 2015-2016 review of 32 RCCs in the northeastern region of the U.S gives good insight into common services provided. According to the study, all 32 RCCs offered social/recreational services and most also provided mutual-help (91 percent), recovery coaching (77 percent), employment assistance (83 percent), education (63 percent) assistance, and overdose reversal training (57 percent).[11] Forty-three percent offered medication assisted treatment (MAT) support.[12]

A 2021 study concluded that peer-based recovery support services, delivered in communities via RCOs are an important part of the continuum of care for individuals with SUDs and those seeking to initiate or maintain their recovery.[13] The report specifically found that RCOs:

- had an average engagement of 130 days totaling 4290 engagement sessions and 8,931 brief check-ins;
- engaged individuals had a **significant increase in recovery capital of 1.33** points from intake; and
- helped to facilitate involvement with an array of recovery support services that may contribute to other functional social determinant domain improvements and lower negative health events.[14]

Case Studies

Freedom Through Recovery: Susan Ford Recovery Community Organization - Statesboro, GA

Based in Statesboro, Georgia, the Susan Ford Recovery Community Organization (known as Freedom Through Recovery, or FTR)[15] is a rural RCO that is also an RCC. The organization was founded and opened in December 2018, a year after the Statesboro community held a Recovery Symposium supported by a grant from the Georgia Council on Substance Abuse and the Georgia Department of Behavioral Health and Developmental Disabilities Office of Recovery Transformation.

Freedom Through Recovery offers an array of non-clinical services to work alongside individuals, and their families, in recovery. They have weekly meetings for peer meditation or prayer, a women's group, alcoholics anonymous, yoga and the 12 steps, professional development, big book study, and a meeting inclusive of anyone in recovery. Certified peers who have been in recovery for a minimum of two years facilitate all meetings. Freedom Through Recovery also employs three full-time staff members who are all in recovery: A director, an operations manager/recovery coach, and a recovery coach.

Continuum Care Center - Saint Paul, MN

Continuum Care Center (CCC)[16] is an RCC and RCO that focuses on providing vulnerable populations with culturally appropriate peer support services. Like other RCCs, the CCC provides key nonclinical services like peer support, recovery navigation, training, and community education.

The CCC is driven by three values: community, culture and ethnicity, and compassion. Although community and compassion are undoubtedly vital in building recovery capital, CCC uniquely calls out the role of culture and ethnicity in an individual's recovery journey, stating that "culture and ethnicity are intrinsic parts of being human and contribute towards personal wholeness."

Recovery Community Center Funding Considerations

While in some instances the Medicaid program will reimburse one-to-one peer-to-peer recovery

coaching services, generally RCCs have no traditional revenue opportunities as they are intentionally structured to provide the community a free resource. Most of the scare RCCs currently in operation typically receive their operational support in part through public grant programs. By design, when providing services and supports to the community it is imperative to secure sustainable and flexible funding in order for the RCCs to provide equitable access.

PEER RECOVERY SUPPORT SERVICES

Background

SAMHSA defines peer providers as, "a person who uses his or her lived experience of recovery from mental illness and /or addiction, plus skills learned in formal training, to deliver service in behavioral health settings to promote mind-body recovery and resilience."[17] However, SAMHSA's current definition does not include certain non-health care settings where Peer Recovery Support Services (PRSSs) are often delivered including schools, probation and parole, churches, jails and prisons, and VA Centers. PRSSs have been essential to long-term recovery success dating back to the formation of Alcoholics Anonymous (AA) in 1935.[18] As recovery support services have evolved over time so has the role of peer support, however, this is not fully acknowledged or funded across the continuum of care. PRSSs in treatment, health system, and community center settings help individuals in recovery reduce substance use and SUD reoccurrence rates, improve relationship with treatment providers and social supports, and increase treatment retention and satisfaction.[19]

In August 2019, a study found that 56 percent of SUD clinical facilities offered PRSSs (n=12,074), meaning the rate of peer services per 100,000 individuals was 2.08.[20] Thirty-one percent of all facilities reported no PRSSs offerings.[21] PRSSs are generally more prevalent in population dense areas but are generally available through the country. Eighty-three percent of long-term residential treatment centers utilize PRSSs, followed by 80 percent of short-term residential treatment centers and 77 percent of transitional housing. Hospital inpatient withdrawal management setting utilize PRSSs the least, at 50 percent. Hospital inpatient treatment settings and outpatient treatment with or without MAT programs utilize PRSSs slightly more frequently at 52 and 54 percent, respectively.[22]

Peer Support Role and Credentials

Core Competencies

SAMHSA defines the peer specialist roles such as developing and maintaining a database of community-based resources, assisting peers to research and services that are right for their own recovery journey, and participate in community activities with peers as requested.[23] SAMHSA defined twelve core competencies for peer works in behavioral health services:[24]

- engages peers in collaborative and caring relationships
- provides support
- shares lived experiences of recovery
- personalizes peer support
- supports recovery planning
- links to resources, services, and supports
- provides information about skills related to health, wellness, and recovery
- helps peers to manage crises
- values communication
- supports collaboration and teamwork
- promotes leadership and advocacy
- promotes growth and development

These competencies shape the role of the peer support specialists. The sixth competency – links to resources, services, and supports – supports the critical role peer specialists have in providing linkage between individuals and community-based recovery services and organizations.

Credentials

In 2017, the Centers for Medicare & Medicaid Services (CMS) required peer support providers to have training and credentialing as dictated by their respective state's regulations. This stipulation led to training program and credentialing variations across the country,[25] including differences in titles, hours of education, practice and supervision, renewal periods, and continuing education requirements.[26] On average, states require 50.43 education hours, 548.03 practice hours, and 49.12 supervision hours. Some states have no hourly requirements for any training. The average renewal period and continuing education requirements across states are 21.74 months and 20.29 hours, respectively.[27]

Workforce Gap

Over the past decade, the uptake of peer recovery coaches has been the largest area of recovery support services growth.[28] However, the broader proliferation of PRSSs are prohibited by the lack of four important components:[29]

- training opportunities for PRSSs in rural and other underserved communities
- field experiences for newly trained peers to build skills and complete certification hours
- experiences certified peer specialists' supervisions for trainees
- employment and career path advancement opportunities for peer support specialists that will provide competitive and equitable wages

In the December 2020 Behavioral Health Workforce Report, SAMHSA calculated that the current workforce of 23,507 SUD-focused peer recovery coaches needed an additional 349,519 coaches – a 97 percent increase – to help meet the current unmet need.

Peer Recovery Support Existing Funding Streams

Medicaid

Georgia was one of the first states to implement peer recovery support services (in 1999) and the first state to make these services Medicaid eligible (in 2001).[30] In 2007, CMS published a letter defining peer services as a reimbursable evidence-based service.[31] While becoming more ubiquitous, PRSSs still vary in roles, credential requirements, and coverage and reimbursement across payers and care settings. In 2018, the Government Accountability Office (GAO) reported that 37 state Medicaid programs covered PRSSs for adults with SUD.[32] Of those, 23 covered PRSSs through state plan authority and nine covered PRSSs under Section 1115 demonstrations allowing greater flexibility to determine the population served and care delivery models. Regardless of authority, state must meet three minimum care requirements to cover PRSSs:[34]

- Peer support providers must be supervised by a competent mental health professional as defined by the state and can vary by scope and duration.
- Peer support providers must be coordinated and integrated in the context of an individualized care plan for a patient.
- Peer support providers must obtain training and certification as dictated by the state.

Of the 65 percent of SUD facility centers that accept Medicaid, 56 percent offer peer providers

while 44 percent do not.[35] In 2019, the average reimbursement rate for HCPS H0038 Self Help/Peer Support for 15 minutes was $13.08, ranging from $8.61 (Kentucky) to $21.23 (Alaska).[36]

Private Insurance

In 2019, 71 percent of SUD facility centers accepted private health insurance as a payer, 56 percent of which offered peer providers.[37] Although rare for private insurers to reimburse PRSSs for SUD, studies across the country have found positive results when health plans are deploying PRSS to commercially insured populations. Blue Cross Blue Shield of Rhode Island (BCBSRI) reviewed three years of commercial data from their Anchor Peer Recovery Center partnership to determine efficacy of services. They found that 65 percent of participants whose treatment included MAT were more likely to stay connected to treatment with peer support. They also found that program participants' medical and pharmacy costs decreased by 12 percent following program engagement, with an anticipated 67 percent decrease in long-term health care costs.[38]

With the influx of digital health solutions in the behavioral health space, private insurance companies and employers are starting to supplement their SUD offerings with these applications, many of which include peer support. In December 2020, Highmark, a Pittsburgh based insurer covering approximately 5 million beneficiaries, announced a new suite of solutions included tele-health for addiction and peer support.[39]

Grant Funded

There are limited funding streams that are able to furnish PRSSs aside from Medicaid or other state-based initiatives. SAMHSA and a variety of states and territories have made funding available through numerous short-term grant programs such as Access to Recovery Grants, State Targeted Response (STR) Grants, Substance Abuse Prevention and Treatment Block Grants (SABG), and Bringing Recovery Supports to Scale Technical Assistance Center Strategy funding.[40]

In June 2021, the Wisconsin Department of Health Services awarded new peer recovery center grants – supported by the state's share of the SABG – to expand offerings to more individuals seeking PRSS.[41] As of 2019, Wisconsin was not using Medicaid to reimburse for services. There are 10 peer recovery centers in the state and five peer-run respites that received additional funding through state block grant funds.[42]

Case Studies

Emergency Department Recovery Coach Services

In 2017, the Connecticut Community for Addiction Recovery (CCAR) deployed peer recovery coaches across the majority of Connecticut hospital emergency departments.

In the first year, more than 97 percent of the emergency room patients that recovery coaches met with were connected to a formal treatment program or recovery support service.[43] CCAR subsequently worked with Yale University to develop a more in-depth evaluation, which showed recovery coaches had a significant impact in Emergency Departments as part of the state response to the treatment of SUDs. In particular, recovery coaches reached over 4000 people with SUDs in Connecticut from March 2017-April 2019 (N=4320).[44] Ninety-nine percent (N=4292) of participants completed a CCAR Recovery Capitol Survey that assessed their internal and external resources available to initiate and sustain their recovery. Almost all participants (96.5 percent) developed a peer

wellness plan with their recovery coach. Recovery plan treatment supports included: withdrawl management, community recovery supports, inpatients treatments, MAT, outpatient treatment, and intensive out-patient connections. From the Emergency Department, participants were connected to the multiple treatments: withdrawl management (50 percent), community recovery supports (32 percent), inpatient (8 percent), MAT (4 percent), and outpatient treatment (3 percent).[45]

Of those referred to the CCAR Recovery Coach program, 68 percent had Medicaid as their primary insurance, 15 percent had private insurance, 10 percent had Medicare, and 7 percent had no insurance or other forms of medical insurance. Twenty-two percent of participants had family engaged in their care. Seven percent of those who engaged with the CCAR Recovery Coach program were diagnosed with overdose. Sixty-three percent of participants said that alcohol was their first drug of use. Twenty-seven percent said that a form of opioid was their first drug of use, with 7 percent saying that cocaine was their first drug of use.[46]

Peer Recovery Support for Justice Involved Populations

"Peer support services for those returning from incarceration with an SUD offers a promising community-based approach to improve treatment adherence and reduce harms associated with substance use."[47]

On January 5, 2015, Pamunkey Regional Jail and The McShin Foundation developed and implemented an authentic peer and recover-oriented system of care for inmates needing recovery from SUDs. The primary focus of the program is to provide hope and recovery to those who want support through ongoing, personal interaction with those living in recovery.

Since the inception of the McShin Program, around 193 male and female inmates have participated in the program. From 2016 through 2018, recidivism rates of inmates who participated in the program were tracked in Pamunkey Regional Jail or any other jail within the state of Virginia. Data was gathered from the jails' records management system, JailTracker, and the Department of Corrections inmate management system, LIDS-CORIS. The Pamunkey Regional Jail recidivism rate for those in the McShin Program was approximately 31 percent, compared to 53 percent across the entire jail population.[48]

RECOVERY HOUSING

Background

As the nation grapples with broad challenges in housing security and accessibility for many, there remain significant gaps in solutions that target those at risk of or are in recovery for SUDs. Housing insecurity and homelessness are significant risk factors that can accelerate the development of SUDs in those without a safe and consistent living environment. Similarly, individuals recovering from SUDs are at risk of a reoccurrence of use if they cannot access stable, safe home environments that can support long-term recovery.

The lack of housing as part of the continuum of care contributes to limitations in treatment engagement, and poor treatment and recovery outcomes. Additionally, lack of housing created log jams in the treatment system, where hospitals and other high intensity clinical programs lag in their ability to release patients back to the community because individuals lack access to safe and supportive housing.

Much like treatment and recovery supports themselves, housing needs fall along a continuum of structured and unstructured housing programs – each tailored to address individuals across a spectrum of SUD diagnosis.

National Association of Recovery Residencies

According to the National Association of Recovery Residencies (NARR), "***Recovery residences*** provide a vital service for initiating and sustaining long-term recovery..."[49] Recovery residences fall on a continuum – from more restrictive and structured programs that may co-locate treatment and recovery services and staff within the residence, to more informal recovery residences, where residents may engage in recovery support services in their communities, but rely on the residence to be a safe space where all who live there are committed to and stable in their recovery. This continuum has been codified in nationally recognized standards created by NARR, through which residential programs can receive accreditation to validate the quality and efficacy of their respective programs.[50]

Higher level recovery residencies as certified by NARR may involve on site recovery support and treatment programs. Current funding avenues that are available for capital improvements or acquisition of property to open such a residence often cannot be used for services provided on site or direct rental access. Enhanced block grant funds for recovery could prove key in supporting programmatic and staffing costs to ensure residencies at that level are able to provide consistent, high quality recovery support services.

Case Studies

Many states have adopted NARR standards in the development of recovery housing infrastructure in their state. While some states have done so through legislative action, others have supported community-based entities that independently certify residencies based on these or similar standards. States and territories then prioritize funding appropriation to recovery housing programs and projects that meet these standards, to ensure a drive towards quality and consistency within the recovery residency market. Thirty states have organizations that are affiliates (they have adopted NARR standards) of NARR, with nine other states in progress of aligning themselves with the national organization.

Massachusetts

The Massachusetts state legislature authorized a voluntary certification process for alcohol and drug free housing in 2016.[51] The Massachusetts Alliance for Sober Housing (MASH) manages the certification process, using NARR standards. Although sober living facilities can operate without certification in Massachusetts, they are unable to receive referrals from state agencies and are not held to NARR standards, which naturally decreases their legitimacy. MASH is an official affiliate of NARR.[52]

New Hampshire

New Hampshire established the non-profit New Hampshire Coalition of Recovery Residences (NHCORR) in 2017 to coordinate state recovery residences and manage recovery residence certification. NHCORR is an affiliate of NARR, meaning they use the standards set by the national organization. Like Massachusetts, state certification is voluntary.[53]

Oxford House

Begun in the mid 1970's, Oxford House is a model of peer-based recovery housing where single-family homes are rented as group homes for individuals in recovery from SUDs. Homes are democratically run and self-supporting; houses must operate based on guiding principles and regulations that are codified in the Oxford House Manual. There are currently over 2,000 Oxford

Houses in the U.S., with at least one Oxford House in all 50 states and in the District of Columbia. SAMHSA recognizes the Oxford House model as an evidence-based model.[54]

Recovery Housing Funding Considerations

As noted previously, states often utilize community-based organizations to provide technical assistance, certification compliance, and monitoring to ensure quality recovery housing supply is available in their jurisdiction. Federal block grant funds can be critical to ensure these certifying bodies have the necessary staffing capacity and technical acumen to monitor, certify and support in an ongoing manner both existing and new recovery housing capacity in their territories.

Lastly – the intersectionality between SUDs and homelessness must not be overlooked. During the COVID-19 pandemic, many states deployed rental assistance and other funds to ensure individuals could remain housed or have the proper financial security to attain new housing if they have been displaced. Since many recovery residencies require rental payments to operate, allowing states to find ways to deploy block grant funds for rental assistance is critical to ensure that individuals in recovery and those struggling with SUDs can access appropriate and stable housing – be it through formalized recovery housing structures, development of voucher programs, or simply ensuring individuals impacted by SUD have the same access to rental assistance as others who may become housing insecure.

EDUCATION-BASED RECOVERY SERVICES

Background

Education-based recovery services are designed to help students achieve their educational goals while supporting their sustained recovery from SUDs or co-occurring disorders. Both colleges and high schools offer education-based recovery support services.

Collegiate Recovery Programs

Collegiate Recovery Programs (CRPs) are institutionally sanctioned program to support college students in recovery by providing seamless access to recovery-related social and other supports and preventing relapse. Brown University developed the first CRP in 1977. The Association of Recovery in Higher Education (ARHE) – the only association exclusively representing CRPs – identifies 143 CRPs currently that span nearly every region of the United States. [56]

While services may vary by location, comprehensive CRPs typically have the following components:[57,58]

- sober housing within the institution – sober-living dorms, houses, or a roommate referral system
- physical space for students to gather together socially, participate in sober activities, and experience peer recovery support in a safe environment
- mutual aid support groups near or on campus for students in recovery
- staff, counselors, or student leaders who are dedicated to the program
- peers, recovery coaches, or counselors who are available for counseling recovery support

- recovery protection services and recovery capital resources
- institutional acceptance of and authority over the program and the academic goals of students in recovery

Data from a 2013 national survey of 486 students in 29 CRPs across 19 states revealed that the average age of participants was 26 years.[59] The majority of the students surveyed reported drug use disorder as their primary problem and alcohol use disorder as their second.[60] Additionally, 83 percent of students reported having received treatment for alcohol and/or drug use prior to enrolling in the program and 93 percent had attended a 12-step program.[61]

Additionally, research suggests that students in CRPs have more successful recovery and better academic outcomes. According to a 2014 study, only 5 percent of students in CRPs reported using alcohol or drugs in the past month – much lower relapse rates compared to the first-year posttreatment relapse rates among youth.[62] Students in CRPs also have almost a 90 percent graduation rate compared with a 61 percent institution-wide graduation rate.[63]

Recovery High Schools

The Association of Recovery Schools defines Recovery High Schools (RHSs) as specialized, secondary education programs that meets the needs of students recovering from addiction.[64] Similar to CRPs, each school may operate differently, but all share four main goals:[65]

1. educate students in recovery from substance use or co-occurring disorders
2. meet state requirements for awarding a secondary school diploma
3. ensure that all students enrolled are in recovery and working in a program of recovery from substance use or co-occurring disorders as determined by the student and the school
4. admit any student in recovery who meets state or district eligibility requirements for attendance (i.e., students do not have to go through a particular treatment program to enroll, and the school is not simply the academic component of a primary or extended-care treatment facility or therapeutic boarding school)

According to the most recent evaluation by the Association of Recovery Schools, there are currently 43 RHSs across 21 states.[66] The association accredited its first school in 2013 and there are now seven accredited RHSs:

1. Archway Academy, Houston, TX
2. P.E.A.S.E Academy, Minneapolis, MN
3. Insight Program, White Bear Lake, MN
4. William J. Ostiguy High School, Boston, MA
5. Hope Academy, Indianapolis, IN
6. Mission Academy, Oklahoma City, OK
7. University High School, Austin, TX

RHSs have received heightened interest from policymakers and funders. Multiple National Drug Control Strategies from 2010-2020 and the 2016 Surgeon General's report have specifically discussed the role of recovery schools in fostering community and peer-based approaches. The Surgeon General's report explicitly mentions the need for more research in this area, and many states have passed legislation authorizing and/or funding RHSs.

A 2017 study found that students enrolled in RHSs were much more likely than those not enrolled in such schools to report being substance free six months after they were first surveyed.[67] Furthermore, the average reported absences among the 134 recovery school students in the study was lower than the other students.[68]

Case Studies

University of North Carolina (UNC) at Chapel Hill Carolina Recovery Program

The Carolina Recovery Program at the University of North Carolina (UNC) – Chapel Hill has a mission "to build and maintain a community that supports continued recovery, academic excellence, and a commitment to serving the greater UNC community."[69] The Carolina Recovery Program offers each student a customized success plan, staff and peer support, and proactive recovery focused programing to help students transition from treatment back to college and enjoy a normal substance-free collegiate experience.[70]

The Carolina Recovery Program uses Soberlink – an FDA cleared device that acts as a comprehensive alcohol monitoring system – to detect whether or not students were returning to use and ultimately promote long-term recovery.[71] The device portable, professional-grade breathalyzer with wireless connectivity, facial recognition, and real-time reporting provides data to help identify recovery challenges and adjust treatment plans as needed.[72] The Carolina Recovery Program found that implementing Soberlink helped increase involvement in the program, enable better communication, and improve relationships with students and support teams. Eighty-two percent of students would encourage other students to use Soberlink and 93 percent of students would encourage other students to use recovery coaching.[73]

The Center for Collegiate Recovery Communities at Texas Tech University (TTU)

Launched in 1986 as one of the first CRPs, the Center for Collegiate Recovery Communities at Texas Tech University (TTU) is the largest collegiate recovery community in the country.[74] The TTU center strives to not only provide support for students in recovery, but also help other universities establish their own recovery programs. In 2004, TTU received a grant from SAMHSA and the Department of Education to "develop a curriculum with step-by-step guidelines and information to assist other universities in establishing collegiate recovery programs of their own."[75] Via a private donation, TTU provides support to other institutions via two efforts: The McKenzie Lectureship Series, which "funds educational opportunities designed to teach professionals, students and the community about the hope that comes through addiction recovery" and the McKenzie Replication Project, which helps TTU disseminate its Collegiate Recovery Community program model to other universities nationwide.[76]

Hope Academy

Hope Academy is one of the seven schools accredited by the Association of Recovery Schools and Indiana's only RHS.[77] The tuition-free, public charter high school has provided a safe, sober, and challenging academic experience for 700 students in 35 school districts across the Indianapolis area.[78] Hope Academy currently has 30 students enrolled, with an average class size of seven. Ninety-four percent of Hope Academy graduates go on to post-secondary education.[79]

Hope Academy provides students with a recovery coach to support their recovery and help them find a sponsor and local meetings to attend twice per week, and hosts circle groups to give students the opportunity to check in on each other about their goals, struggles and what support they need. [80] The school conducts bi-monthly drug tests to hold students accountable for their sobriety.[81] A failed drug screen does not automatically result in expulsion, but can be a sign that the student needs additional support.[82]

On July 13, 2021, Hope Academy became the newest Indianapolis Simon Youth Academy

and a recipient of one of 10 student recovery grants to support post-secondary scholarships, teacher professional development, workforce development collaborations, student college visits and civic learning trips, and student resources and technology.[83] In partnership with Simon Youth Foundation, the school aims to "provide Indianapolis area teens who are in jeopardy of dropping out of high school with the tools and resources they need to graduate and prepare for their post-graduation career path."

RECOVERY SUPPORT HIGHLIGHTS TARGETING SPECIFIC POPULATIONS

Background

As with other chronic illnesses, the disease burden of SUDs disproportionately impacts communities of color and other specific populations, including (but not limited to): BIPOC, Native American/ANAI, Justice involved, Latinx, LGBTQIA+, and Veterans.

While all services supported with block grant and other funds should ensure culturally responsive services are provided, scaling the nation's recovery supports ecosystem must include the scaling of recovery support services that are led by, and focused on, these specific populations. Given the peer-led nature of recovery supports, it is critical that states and territories look to support not only recovery support services that can serve a broad population, but services and supports operated and led by and for people from these populations.

Current Programs

There are many organizations providing recovery support services for people of color, LGBTQIA+, and other specific populations. Below are several examples:

- **The African American Federation of Recovery Organizations (AAFRO)** is a culturally specific organization created by subject matter experts, leaders, and founders of African American peer led RCOs.[84]
- **Recovery Dharma** is an international organization that supports individuals in recovery through Buddhist techniques. It is self-described as a grassroot, peer-led, and democratically-structure group. They hold both online and in-person supports, with specific groups for specific populations like BIPOC and LGBTQIA+.[85]
- **White Bison** is a national recovery program, based in Colorado Springs (CO), aimed at supporting Native American/Alaskan Native communities. White Bison is a part of the Wellbriety Movement, which simply aims to bring sobriety and wellness to participants. The main enhancement of the Wellbriety Movement is the addition of, and commitment to, wellness, on top of sobriety and recovery.[86]
- **Hollywood and Vine Recovery** is a charity that has been facilitating peer-led discussions about solutions to alcoholism, addiction, mental, and emotional health suffering for over 60 years. Peers lead newsletters, blogs, and many individuals, both staff and alumni, are people of color or LGBTQIA+, among other often marginalized communities.[87]
- **Recovery Is Happening (RIH)** is a recovery community organization based in Rochester (MN). Along with a full slate of recovery support services, RIH provides support for incarcerated individuals. Acknowledging that support in recovery is vital while incarcerated, and that recovery can be difficult upon release, RIH provides one-on-one support in and out of jail, supplemented by peer support groups in the community.[88]
- Although not a national organization, **Veterans Recovery Resources** has been serving fellow military veterans with tailored addiction treatment and recovery support services in

the Mobile (AL) area since 2016. Started by a veteran who was having a hard time adjusting to civilian life after returning home from service, the organization provides an array of services from primary care to peer support.[89]

- **Rest for Resistance** is a group started by QTPoC Mental Health that hopes to support communities, like BIPOC, who are often marginalized in general, but also experience gaps in access to health care and social supports.[90]
- **QTPoC Mental Health** was founded in 2015 by trans and queer people of color as a grassroots trans-led organization that creates online and offline spaces for trans & queer people of color, and other stigmatized groups, to practice being more whole.[91]
- **The National Queer and Trans Therapists of Color Network (NQTTCN)** is a national group dedicated to increasing access to key mental health resources for queer and trans people of color (QTPOC). Started in 2016, are self-described as sitting "at the intersection of the mental health field and movements for social justice."[92]

It is important to note as well that harm reduction services – which are designed to keep safe those who are actively using drugs – are often not considered traditional recovery support services. Yet, harm reduction programs can often be a powerful point of first contact, which can move active users through the stages of change and motivate them to seek treatment and recovery. Too often, SUD services are designed in ways that exclude engagement of active users. In contemplating further evolution of recovery supports, policy makers should consider active users as a special population and encourage states and territories to ensure that active users can appropriately access services that may enhance the likelihood of treatment and/or recovery support engagement.

CONCLUSION: OPPORTUNITIES FOR EXPANSION AND SCALING

Improving long-term recovery outcomes clearly benefits individuals, families, communities, and the nation. The Facing Addiction in America report indicates that every $1 invested in addiction treatment will save $4 in health care costs, and $7 in criminal justice related costs.[93] For example, in Missouri, the average cost to the state per recovery support service enrollee is $687.34 and for each person in recovery the state estimates a cost savings of $18,888.[94]

A variety of surveys of the recovery community indicate that steady employment increases by 50 percent for those in sustained recovery. Furthermore, people in recovery utilize costly emergency room departments seven times less frequently than people in active addiction, at 3 percent vs. 22 percent respectively, and decrease their rates of contracting infectious diseases such as Hepatitis C and HIV/AIDS from 17 percent in addiction to 4 percent in recovery.[95] Notably, the percentage of uninsured decreases by half, from 39 percent in active addiction to 20 percent in recovery. Lastly, untreated emotional/mental health problems fell from 68 percent in active addiction to 15 percent in recovery.

The prevalence of RCOs remains an enormous equity gap for SUDs when compared with other services along the continuum of care, as illustrated in Figure 3.

Figure 3: Currently There Are 150 RCO's When Compared With...

Type of Center	Number
SUD Treatment Programs	15,961
Prevention Coalitions	5,000+
Prisons and Jails in America	4,013

Bold investments are still needed to ensure that every individual seeking recovery is able to receive ongoing supports to help them sustain long-term recovery. As SAMHSA stated in the agency's FY2022 Budget Congressional Justification for a proposed 10 percent Recovery Support Set-Aside in the SABG program:

"It is imperative that our addiction crisis response evolves from an acute short-term individual- focused treatment response to a broader community recovery response. Addiction is a chronic illness, and recovery often is a life-long process where external community and social determinants of health play a vital role in its sustainability. The Budget Request includes a new 10 percent set aside within the SABG for recovery support services in order to significantly expand the continuum of care both upstream and downstream. This new set-aside will support the development of local recovery community support institutions (i.e. recovery community centers, recovery homes, recovery schools, recovery industries, recovery ministries); develop strategies and educational campaigns, trainings, and events to reduce addiction/recovery-related stigma and discrimination at the local level; provide addiction treatment and recovery resources and support system navigation; make accessible peer recovery support services that support diverse populations and are inclusive of all pathways to recovery; and collaborate and coordinate with local private and non-profit clinical health care providers, the faith community, city, county, state, and federal public health agencies, and criminal justice response efforts."

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