



Optimizing Recovery Funding, Volumes 1 & 2

**Volume 1: Barriers to Acquiring Funding for
Organizations in the Ecosystem of Recovery**

**Volume 2: Strategies for State Funding of
Recovery Support Services**

January 2023



Disclaimer Statement

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January 2023

Executive Summary

The Substance Abuse and Mental Health Services Administration (SAMHSA) provided the Peer Recovery Center of Excellence (PR CoE) with supplemental funding for a special project to identify and recommend best practices and strategies to optimize funding for high quality and effective recovery support services. The PR CoE's two-part approach for this project involved an assessment of the opportunities and barriers experienced by organizations in the ecosystem of recovery in accessing funding and a deep-dive analysis of how states are administering funds to support recovery services. Both parts of the project were conducted in collaboration with a panel of subject matter experts including individuals with lived experience in recovery.

This report presents the findings and policy recommendations of the Optimizing Recovery Funding project. This report is split into two volumes.

Volume 1 reviews the methods, findings, and recommendations from a national assessment of the challenges and successes experienced by organizations in the ecosystem of recovery in securing sustainable funding.

Key findings include:

- Federal grant applications are highly complex and organizations do not receive useful feedback or resources on how to improve their submissions.
- Requirements for the receipt of federal funding often necessitates resources for organizational grant administration, which are not allowable expenses in the grants.
- Organizations primarily serving underserved and minoritized communities feel excluded from existing funding opportunities.
- Existing funding streams often have restrictions that limit their utility in supporting the implementation of recovery support services, requiring diversified funding for sustainability.

In response to these findings, the PR CoE offers the following recommendations:

1. SAMHSA should reduce the complexity of the grant process and provide feedback and customized support for recovery community organizations and peer-run organizations to build their capacity to win grants.
2. Federal and state funding agencies should provide greater flexibility in the allowable use of funds, a longer time period in which to spend the funds, more information about recovery funding opportunities, and additional resources for community recovery organizations.
3. Funders should develop inclusive and culturally responsive funding opportunities that take into consideration the unique needs of historically underserved communities, such as the fact that data may be lacking for such communities.
4. Funders should support funding for recovery organizations' entire portfolio of recovery services and reduce the administrative burden of grants management to provide time and space for these organizations to focus on sustainability.

Volume 2 reviews the methods, findings, and recommendations from the analysis of how states allocate funding to organizations for recovery support services (RSS).

Key findings include:

- The 32 state respondents reporting full financial information spent \$412M on RSS from substance abuse block grants, discretionary grants, and state appropriations. This funding was spent on six categories of recovery support services in fiscal year 2022. When extrapolated to all 50 states (using per capita averages), this represents an estimated \$718M nationally.
- When correlated with data on substance use disorder prevalence, the RSS spending ranged from \$9.40 to \$28.60 per capita for persons with substance use disorders, with an average of \$20.78 for all states.
- Spending by source shows that discretionary funding, which could include time-limited funds, makes up one-third of the total RSS spend.
- Recovery community organizations were the organization type identified by most states as providers of RSS, followed by substance use disorder treatment organizations, and then mental health treatment organizations, community health centers, educational institutions, and a large mix of other organizations. In review of total funding allocated, treatment providers received approximately 2.5% more funding for RSS than recovery community organizations did.
- Both community and government stakeholders noted the need for clear reporting requirements and standardization of definitions of recovery support services in order to adequately track and report what was offered to whom and with what effect.
- The analysis identified the need for additional efforts to reach and support peer-led community-based organizations, especially among Black, Indigenous, and People of Color; Lesbian, Gay, Bisexual, Transgender, Queer, Two-Spirit (LGBTQ2S+); rural; and other underserved populations.

In response to these findings, the PR CoE offers the following recommendations:

1. States should report to SAMHSA the amount of money from substance abuse block grants and other discretionary grants spent on recovery support services, in broad domains that reflect the expenditures.
2. Funding agencies should develop approaches to expand and diversify the applicant field in order to better match community needs, address gaps, and build capacity to apply for and manage grants, especially for previously unfunded and underrepresented organizations.
3. States should establish and increase opportunities for training, technical assistance, toolkits, and learning collaboratives, specific to funding recovery support services.
4. SAMHSA should initiate a consensus process to develop a taxonomy of recovery support services that is useful for reporting performance and outcomes.
5. Funders should create mechanisms to better coordinate and align goals of interagency funding of recovery support services at both state and federal levels.
6. SAMHSA should initiate a follow-up to the systematic review of evidence on recovery support services presented to the SAMHSA Recovery Research and Evaluation Technical Expert Panel in 2018.
7. The Office of Recovery in SAMHSA should clarify and communicate the vision for recovery support services, including distinctions as applicable between mental health and substance use disorders.

Welcome Letter

Dear Colleagues and Friends,

Thank you for your interest to learn more about the opportunities and challenges we collectively face in optimizing funding for recovery support services (RSS). If you are new to the Peer Recovery Center of Excellence (PR CoE), allow me to take a few lines here to share about the Center.

Since our inception in the late summer of 2020, the PR CoE strives to enhance and support the field of peer recovery support services. We accomplish that vision through providing training and technical assistance designed to build and elevate an equitable peer workforce to deliver peer recovery support services. Our focus areas include supporting the integration of peer recovery support services across a variety of settings, building capacity amongst new and existing recovery community organizations (RCOs), supporting peer workforce development, and promoting and disseminating both evidence-based practice and practice-based evidence. To learn more about us and how you or your organization could benefit from our support, I encourage you to visit our website at www.peerrecoverynow.org.

The PR CoE is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide technical assistance and training to the field for substance use disorder recovery support services. This report, *Optimizing Recovery Funding*, is reflective of recovery support services across the broader continuum of the ecosystem of recovery. As such, it encompasses recovery community organizations, recovery community centers, peer recovery organizations, recovery housing, recovery high school and collegiate programs, recovery peer support, recovery cafés, and any other type of organization that provides substance use disorder recovery support services. In addition, the PR CoE purposely sought to understand the needs and elevate the voices of organizations in the ecosystem of recovery that serve historically underserved and/or minoritized populations.

As you read this report, you will note two main themes - the complexity of both federal and state funding applications and the need for the type of detailed training and feedback necessary for smaller community-based recovery-oriented organizations to successfully compete for and manage public dollars.

As a person in long-term recovery, I understand the truly magnificent experience of moving from a place of hopelessness to one of unlimited possibilities. And I sincerely believe that opportunity exists for every person who experiences significant challenges with substances. Growing recovery-ready communities hinges on a network of robust RSS designed and implemented at the grassroots community level. The findings and perspectives contained within this report provide valuable insights to the path moving forward.

Thank you for all you do to make a difference.

With gratitude,

Sharon Hesseltine
Steering Committee Chair
Peer Recovery Center of Excellence

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Optimizing Recovery Funding, Volume 1:

Barriers to Acquiring Funding for Organizations in the Ecosystem of Recovery

August 2022



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1. Introduction

1.1 Background and Objectives

The Substance Abuse and Mental Health Services Administration (SAMHSA) awarded the Peer Recovery Center of Excellence (PR CoE) grant (#5H79TI083022) to the University of Missouri – Kansas City (UMKC) in 2020. The PR CoE provides training and technical assistance to build and elevate an equitable peer workforce to deliver peer recovery support services for individuals and families with substance use disorders (SUDs). We accomplish this through supporting peer integration, recovery community organization (RCO) capacity building, peer workforce development, and evidence-based practice dissemination. At the end of the first year of funding, SAMHSA provided the PR CoE with supplemental funding for a special project to identify and recommend best practices and strategies to optimize funding for high quality and effective recovery support services. UMKC’s two-part approach for the special project involves a deep-dive analysis of how states are administering funds to support recovery services and an assessment of the opportunities and barriers experienced by organizations in the ecosystem of recovery in accessing funding. This initial report presents the findings of the Optimizing Recovery Funding organizational assessment.

Early in the PR CoE funding period, the team conducted a needs assessment to support programmatic design titled, “Building and Strengthening the Capacity of Recovery Community Organizations.” Results are available on the PR CoE website, <https://peerrecoverynow.org/>. That assessment found that limited access to funding is a primary threat to the sustainability of RCOs. The Optimizing Recovery Funding assessment builds off the original assessment. The purpose is to learn from peer recovery support service providers, across all states, about their main barriers in acquiring funding as well as potential solutions to overcoming these barriers. Results from our nationwide survey and focus groups provide the first comprehensive picture of these challenges from leaders of organizations in the recovery ecosystem. We highlight the perseverance of many organizations in the ecosystem of recovery that continue to deliver peer recovery services despite major challenges to their sustainability.

1.2 Role of SME Panel

A key tenet of the recovery community is “nothing about us, without us.” In order to honor this principle and to be as inclusive as possible in the development, implementation, and dissemination of the Optimizing Recovery Funding project, we convened a Subject Matter Expert (SME) Panel. The panel consists of sixteen individuals with lived experience of recovery from substance use disorders, who operate or have operated RCOs, who are current or former state substance use authorities (SSAs), and/or who represent recovery advocacy or other stakeholder organizations. The purpose of the SME panel is to help us ensure that the methodology, instruments, processes, analysis, and final report are inclusive and reflective of the needs and experiences of the recovery community. Panel members reviewed our proposed methodologies, drafts of survey and focus group questions, and participant recruitment materials. They were instrumental in procuring our sample, and provided feedback on survey and focus groups results, consulting on the coding scheme and reviewing the report of the findings. A list of the panel members is provided in section 5.

1.3 Defining the Ecosystem of Recovery

The original priority population of this assessment was RCO leaders. With guidance from the SME panel, this focus was expanded to include leaders of any organization in the ecosystem of recovery. Five core pillars describe the ecosystem of recovery: save lives, engage community, expand treatment, screen for and prevent substance use disorder, and support recovery (Lawrence, 2021). This ecosystem includes recovery community organizations, recovery community centers (RCCs), peer recovery organizations, recovery housing, recovery high school and collegiate programs, recovery peer support, and recovery cafes (FAVOR, 2021). It also includes the micro, meso, and macro levels of an individual’s recovery support system (Ashford et al., 2020). In short, RCOs, peer recovery organizations, or any other type of organization that provides SUD recovery support services are part of the “ecosystem of recovery,” regardless of whether the organizations meet the criteria for an RCO.

1.4 Quality Improvement, Not Research

Prior to the onset of this assessment, the University of Missouri’s Institutional Review Board (IRB) categorized our proposed work as quality improvement—not human subjects research. Although we surveyed and interviewed people—the leaders of organizations in the ecosystem of recovery—they spoke on behalf of the experiences of their organizations, which were not deemed human subjects by the University of Missouri’s IRB. As a condition of this IRB determination, none of the work in this assessment can be labeled as research, although we still utilized scientific principles in study design and analyses. We also employed best practices regarding data security, confidentiality, and anonymity in this assessment as if participants were part of a human subjects research study.

1.5 Characteristics of Participating Organizations

1.5.1 Survey Sample

Quantitative analyses of the survey stem from an analytic sample of **158 organizations in the ecosystem of recovery who participated in our survey**, titled “Needs Assessment to Optimize Access to Funding for Organizations in the Ecosystem of Recovery Across the US”. There were no duplicate entries from organizations. Responses came from leaders of organizations such as CEOs, Presidents, Executive Directors, Directors, Program Managers, and individuals with other leadership roles and titles. Most organizations (N=135; 85.5%) had more than 50% of their staff members with lived experience of recovery from SUD. The vast majority (N=144, 91.1%) already had a 501(c)(3) IRS non-profit status tax exemption.

Of the 158 organizations comprising the survey analytic sample, **76 (48.1%) identified as a freestanding/independent RCO or Recovery Community Center (RCC)**; they were

not distinct programs of larger umbrella organizations that provides administrative and/or operational supports nor did these organizations primarily focus on substance use disorder treatment in addition to providing recovery support services. The other **82 (51.9%) organizations in the ecosystem of recovery did not identify as an RCO or RCC, or indicated they were not freestanding/independent**. Among the 158 organizations in the survey sample, 33 (20.8%) estimated that a majority of the community members they serve are people of color.

Percentage with 501(c)(3)
Tax Exemption

91.1%

N = 144

We purposely sought to understand the needs of organizations in the ecosystem of recovery that serve historically underserved and/or minoritized populations. Organizations could select all that applied for whom they primarily focus on providing services. These included 28.5% focusing on members of the LGBTQIA+ community; 19.6% focusing on community members with disabilities; and 39.2% for justice involved members. However, there is overlap in population coverage among these organizations.

1.5.2 Focus Group Sample

Qualitative analyses of **16 focus groups** stem from **85 participants**. The focus groups were devised to capture geographic breadth and to be inclusive of organizations that typically serve community members of underserved and/or minoritized groups in the United States, including the territories.

By **DHHS region (see Appendix)**, there were 10 focus groups: Region 1, 2, 3, 4, 5, 6, a combined 7/8, 9, 10, and one mixed with several regions.

By **population identity**, there were 6 focus groups: Black Voices, Asian American and Pacific Islanders, Native American and Tribal Communities, Latinx 1 (in English), Latinx 2 (in Spanish), and LGBTQIA+.

Primary Focus of Organizations



28.5%

LGBTQIA+ Community

19.6%

**Community Members
with Disabilities**

39.2%

**Justice Involved
Members**

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2. Methodology

2.1 Mixed Methods Approach

We designed this quality improvement study with a quantitative and qualitative component to benefit from the breadth—via surveys—and depth—via focus groups—of organizations' leaders' experiences in acquiring recovery funding. This project is considered mixed methods not solely because multiple empirical methods of data collection and analysis are used, but because of their essential analytic connection. Data from the survey, described below, provide a sense of patterns and range of experiences across many different types of organizations in the ecosystem of recovery. This information was used to develop a focus group guide. The focus group data provided detailed insight into these organizations' efforts to acquire recovery funding, which offered necessary context to interpret the larger-scale results of the survey. The quantitative and qualitative parts of this project, together, provide comprehensive analyses.

2.2 Initial Sample List

Our initial sample list was an existing list of recovery community organizations developed by the PR CoE for marketing purposes. This list used the William White definition of a Recovery Community Organization (Valentine, White, & Taylor, 2007) and each organization was vetted to ensure it was: peer-centered; 51% of board directors had lived SUD experience; independent; non-profit; led by local community members of recovery; and not primarily clinical. This list contained 228 organizations. Information from these organizations was confirmed through email, online, and/or phone verification and updated with any missing contact information where available. We provided a list of the RCOs in our list for each DHHS region to the directors of the Addiction Technology Transfer Center (ATTC) that corresponded to the region. The ATTC teams reviewed the lists and provided additional organizations and any missing contact information. From these organizations, the list was expanded from 228 to 330 organizations.

2.3 Expanding the List

After updating the list of RCOs with ATTC input, we engaged the SME panel members to expand the sample further and ensure we were inclusive of all states and territories. These discussions resulted in an expansion of the directory to all organizations that provide SUD recovery services, namely the ecosystem of recovery (see section 1.3). Due to a number of factors, including the lack of a central database with the names and locations of these entities, recovery organizations or organizations that provide recovery services are not easily defined or identified. Some organizations may not call themselves recovery community organizations but should be included as they still provide recovery services, seek funding, and sustain long term recovery in the community. Based on feedback from the SME panel, the final survey asked organizations if they identified as any of the following: Recovery Community Organization, Peer Recovery Organization, Recovery Community Center, Recovery Coalition, Recovery Clubhouse, Recovery Café, Sober Support Group, Recovery High School, Collegiate Recovery Program, Recovery Housing, or another category. Any further organizations in the ecosystem of recovery suggested by either the ATTC Directors or SME Panel were vetted to confirm they provided SUD recovery support, regardless of whether those organizations meet the criteria for an RCO. This resulted in a final sample of 537 organizations across 46 states, 3 territories, and the District of Columbia.

2.4 Quantitative Methods

2.4.1 Survey Sample Recruitment

Although we procured an extensive—and currently the most comprehensive—list of organizations in the ecosystem of recovery, from which to sample, the true number of such organizations remains unknown. Beginning on March 23, 2022, we recruited organizations through REDCap, a standard online survey collection software, with the email addresses we procured. Each week, until April 22, we contacted organizations who had not yet participated, despite being invited, in addition to those who had begun the survey but not completed it.

In total, 204 organizations in the ecosystem of recovery participated in our survey. Of these 204 organizations, only 1 indicated that they did not consider their organization to be a part of the ecosystem of substance use recovery; the survey instrument did not allow for further participation in the study. Further, 45 (22.2%) only completed the initial screening questions determining their study interest and eligibility. Data collected in REDCap were exported to Stata, a statistical analysis software package.

2.4.2 Analytic Techniques

Given that the true “population” of organizations in the ecosystem of recovery is unknown—even with our extensive efforts to produce the most comprehensive list to date—and the relatively small population size (N=537), it was not possible to either survey ALL organizations or randomly sample in a statistically meaningful way. Thus, the 204 organizations who participated comprise a **convenience sample**; we can only provide descriptive, not inferential, statistics in our analyses. Nonetheless, we are still able to provide valuable comparisons between independent/freestanding RCOs and RCCs versus other types of organizations, in addition to distinguishing between organizations that predominantly serve community members of color and those that do not. Despite not being **statistically** representative of all organizations in the ecosystem of recovery, the survey sample and analyses capture their heterogeneity.

2.5 Qualitative Methods

2.5.1 Focus Group Sampling

Most of the 85 participants comprising 16 focus groups participated in, and were recruited from, the survey. Survey participants were given the option to express interest in participating in follow-up focus groups describing their successes and challenges in their organizations’ efforts to acquire funding. Given the 60-to-90-minute duration of focus groups, participants were enticed by being compensated \$50 for their time. In cases of organizations serving underrepresented community members, such as Native Americans and Asian Americans and Pacific Islanders, SME panel members reached deep into their networks of contacts to ensure participation in these focus groups, also with the same time compensation.

2.5.2 Analytic Techniques

The 16 focus group sessions were held virtually via Zoom technology and facilitated by several report authors—Tyler Myroniuk, Enid Schatz, and Deena Murphy and, in several instances, SME panel members or others who represented the audience of focus for the group (e.g., Tribal communities). Individuals who are not report authors who provided facilitation services of focus groups were: Laurie Johnson-Wade, Pata Suyemoto, Maxine Henry, Ruth Yáñez, Gabrielle Rodriguez, and Troy Montserrat-Gonzales. Additionally, at least one member

of the PR CoE team, including Stephanie Spitz, Stephanie Bage, Crystal Jeffers, and Zoë Sullivan-Blum, sat in on each focus group to provide technical support and take notes. Focus group sessions were recorded and transcribed.

We conducted the qualitative analysis in four phases using ATLAS.ti software. Our coders employed thematic analysis (Guest, MacQueen, and Namey, 2012) to guide this process. In the first analytic phase, three coders conducted an initial coding test on the same two focus group transcripts to identify common themes. The group agreed to a set of 12 themes; coding definitions were then developed through consensus. In the second phase, two more coders joined and, thus, five coders conducted a coding test—with the code and definitions guide—on the same focus group transcript. At this point, the coders resolved the few remaining coding discrepancies; trustworthiness of coding, between coders, was achieved. In the third phase, four of the coders were randomly assigned the remaining focus group transcripts to code. In the fourth, and final, phase, focus group data were aggregated and sub-themes—presented in this report—were identified. The qualitative data presented in the report are emblematic, and best representations, of the themes uncovered in our analyses.

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3. Findings

3.1 “They are so overwhelming”: Grant Applications and the Need for Training

Organizations in the ecosystem of recovery cannot receive the benefits of federal funding if they do not know how to apply, or feel discouraged from applying, due to complexities in writing and submitting grants as well as the time needed to do so. The link between the complexity of grant applications and opting out of even submitting grant applications is problematic. Not surprisingly, more guidance and feedback is required for organizations to successfully compete for grants. We highlight two main themes below: the **Complexity of SAMHSA Grant Applications** and the **Need for Detailed Training and Feedback**.

3.1.1 The Complexity of SAMHSA Grant Applications

The ability for organizations in the ecosystem of recovery to be successful in acquiring federal funding requires submitting grant applications. As shown in Table 1, only 55.1% of all organizations applied for funding directly from the federal government (with independent RCOs and RCCs doing so slightly less than other types of organizations). Substantially more—77.2%—applied for state funding.

Table 1. Has your organization ever applied for funding directly from a FEDERAL or STATE government agency or department?

	Federal Government			State Government		
	Independent RCOs/RCCs	Other Peer Organizations	All Organizations	Independent RCOs/RCCs	Other Peer Organizations	All Organizations
No	N = 34	N = 26	N = 60	N = 16	N = 13	N = 29
%	44.7	31.7	38.0	21.1	15.9	18.4
Yes	N = 40	N = 47	N = 87	N = 59	N = 63	N = 122
%	52.6	57.3	55.1	77.6	77.8	77.2
Don't Know	N = 1	N = 8	N = 9	N = 0	N = 5	N = 5
%	1.3	9.8	5.7	0.0	6.1	3.2
Prefer Not to Answer	N = 1	N = 1	N = 2	N = 1	N = 1	N = 2
%	1.3	1.2	1.3	1.3	1.2	1.3
Total	N = 76	N = 82	N = 158	N = 76	N = 82	N = 158
%	100.0	100.0	100.00	100.00	100.00	100.00

It is possible that there are more state funding grant opportunities available—and that some of these are available because of federal block grants. However, the complexity of SAMHSA applications is a notable barrier; it was most consistently ranked as the top barrier in acquiring federal funding—out of 12 choices—for independent RCOs and RCCs (31.3%) and other peer recovery organizations (22.8%).

“
...I think that
it's just so
overwhelming...
— Region 5 Group
”

Focus group participants explained that the complexity of SAMHSA grant applications deterred them from applying for funding. One organization's leader said, “There are so many different [funding] sites... And for some people, I think that it's just so overwhelming. It's just big, and traversing all of it is time consuming when you need to be doing something with the people” (Region 5 Focus Group).

Confusing directions and redundant document submissions were also derided by leaders of organizations in the ecosystem of recovery. “The directions are like, ‘Here's some directions up here, here's some in the middle for the same section...and here at the end we've got some more directions that were supposed to go at the front.’ It's not a step by step... I've been through college and I'm just like, what is this?” (Region 3 Focus Group).

Another leader from the Region 7/8 Focus Group was frustrated by repeatedly needing to input the same documentation for each grant submission. “...Take my 501(c)(3) proof once. Let me stick all of that stuff in a database that everybody has access to, so I'm not continuously uploading attachment this, attachment that, which is the same 20 things that every other grant has asked for...Financials...let me just put those in once a year, please, or even twice a year. But every single time you apply for the grant is just silly. Like why can't [SAMHSA] just have that stuff in one database that they can all find?”

While the complexities of writing SAMHSA grants deter some grant submissions and frustrate the leaders of organizations, it does not mean that all organizations will stop trying to apply; they could use more guidance though.

“
...Take my 501(c)(3)
proof once...Like why
can't [SAMSHA] just
have that stuff in one
database that they can
all find?
— Region 7/8 Group
”

3.1.2 Detailed Training and Feedback

If organizations had applied for federal funding to support peer recovery services, there was still a relatively high success rate in acquiring funding; about 60% of organizations who applied for federal funding were successful. More detailed training and feedback were routinely called for by organizations in the focus groups, echoing the 42.1% of independent RCOs and RCCs, and 34.2% of other types of organizations, who indicated that training or technical assistance would improve opportunities to receive federal funding (Table 2).

Table 2: In which ONE of the following areas do you believe support, training, or technical assistance would improve your opportunities to receive federal and/or state funding?

	Independent RCOs/RCCs	Other Peer Recovery Organizations	All Organizations
Information Technology	N = 3	N = 5	N = 8
%	4.0	6.1	5.1
Administrative Support	N = 15	N = 19	N = 34
%	19.7	23.2	21.5
Data Collection	N = 20	N = 15	N = 35
%	26.3	18.3	22.2
Grant Writing	N = 32	N = 28	N = 60
%	42.1	34.2	38.0
Other	N = 4	N = 7	N = 11
%	5.3	8.6	7.0
Don't Know	N = 1	N = 8	N = 9
%	1.3	9.8	5.7
Prefer Not to Answer	N = 1	N = 0	N = 1
%	1.3	0.0	0.6
Total	N = 76	N = 82	N = 158
%	100.0	100.0	100.0

The sentiment from a LGBTQIA+ focus group participant, below, was virtually universal. Nearly all leaders of organizations in the ecosystem of recovery who participated in focus groups recognize they could benefit from more training on applying to SAMHSA grants.

“I think I agree that the process is just really intense and it’s like ‘check all the boxes and if you miss one box, you’re not eligible,’ which can be very disheartening for someone who spent all that time writing these grants. But I think as far as the length of resources, there are people who are out there successfully writing grants and doing successful programs for SAMHSA, and I think it would be great if they would do like some trainings or some gatherings for other smaller agencies and other smaller communities to learn how to do this stuff.”

— LGBTQIA+ Focus Group

In addition to this call for more training, organizations’ leaders called for more-focused training. Given the time commitments that over-stretched organizations have to commit to attend training sessions—let alone the time needed to apply for federal funding—innovative and incentivizing suggestions were provided, such as that from a leader of an organization predominantly serving Asian Americans and Pacific Islanders.

“I think the idea of training folks is nice but that just takes time and everyone who’s already doing this work is already, you know, working at max overcapacity. So I’d like to offer if SAMHSA is willing to train folks that this is actually a pipeline for people to get funding...if you go through the training, you’re guaranteed some pot of money...that would really encourage a lot of small groups to apply. And, it would also allow them to understand, you know, what is the process like? And that’ll also build their capacity for future applications and potentially bigger pockets of money.”

— Asian American and Pacific Islander Focus Group

Receiving more detailed feedback from SAMHSA prior to a full application process would be valuable to organizations’ leaders—especially if writing an application takes an enormous amount of time. Foundations, for example, sometimes use a letter of intent process prior to a full application. “The feedback we got was, we didn’t hit certain things they were looking for, as far as a more in-depth description of something...Don’t make me do 60 hours when I’m not even going to be in the running. Weed me out a little bit. Tell us, if there’s 30 chances, one per state, ‘don’t get your hopes up high,’ and have a simpler process to weed it out... The ones who get through phase 1, of whatever weeding out process, then give them the 60 hour grant to do” (Region 3 Focus Group).

“Don’t make me do 60 hours when I’m not even going to be in the running.”

— Region 3 Group

3.2 “No amount of spaghetti suppers are going to raise 20 grand for an audit”: Calls for Fundamental Changes to Funding Peer Recovery Services

Focus group discussions illuminated the desire for major changes in efforts to increase the chances of federal and state funding to directly impact the recovery community, as well as reducing the restrictions and stipulations that come with government funding. Even though leaders of organizations in the ecosystem of recovery recognize the responsibility that government bodies have in combating a systemic public health and medical issue such as SUD, the overall funding system would benefit from changes, such as the ones described below.

3.2.1 Getting Funds to the Community Level

“
Make it so we’re not competing against all these really big guys, these big companies or organizations out there.
— Region 3 Group

With SAMHSA providing the largest pool of funds to support recovery, focus group participants identified key barriers in the way of getting funds to the community level. “... there’s only one SAMHSA grant opportunity that the eligibility is limited to peer-run community organizations. When we talk about there being a lot of competition, having more grant opportunities, whether it’s having more grants being offered for the BCOR [Building Communities of Recovery] RFP [Request for Proposals] each year, that would be really helpful, or having more different programs, or some priority was given to peer-run community recovery organizations. Make it so we’re

not competing against all these really big guys, these big companies or organizations out there” (Region 3 Focus Group).

In most focus groups, organizations’ leaders strongly questioned whether federal funding that had been allocated to states was being re-distributed as intended to reach community level recovery supports. Such sentiments demonstrate that these leaders are mistrustful of their governments’ commitment to helping those living with SUD via peer recovery.

“
“I will just be candid with you. SAMHSA wants to know why isn’t the money reaching the communities?...Because the way the system is setup is from the federal government—it goes to the states, the states then disseminate it to the counties, then the counties are to distribute it throughout. And many of these places have gotten into the recovery business. So the money stops. It doesn’t come down. If the state says we want to get into the business of recovery, then it stops at that level.
— Black Voices Focus Group

While there was a general concern about funding reaching community members—at large—focus group participants noted that funding might prioritize some forms of SUD, over others, in seemingly inequitable ways. It was perceived that there was a zero sum game with the opioid epidemic, for instance; emphasis on recovery for those with alcohol use disorder was no longer prioritized. “Listen, I get myself in trouble a little bit, because my two biggest gripes with federal funding is, one, it felt like, for a long time, the only funding that came out was opioid-related.

Well, there's a lot of other substances out there. They finally opened that up to stimulants. Listen, alcohol use disorder is probably one of the most impactful substance use disorders there is. Like, we can't ignore that. We have to be equitable in substance use. And polysubstance use and whatever else. So it's the restrictions of federal funding based on substances" (Region 2 Focus Group).

3.2.2 Tension between Governmental Bureaucracy and the Mission of Organizations in the Ecosystem of Recovery

The focus group participants noted that funding restrictions can make it difficult for them to achieve their communities' goals. Conditions attached to funding might even make them decide that it is not worth receiving these dollars, especially if they felt that the conditions interfered with their organizational mission. Fewer contractual stipulations, or more transparency around the reason behind such stipulations, may allow organizations more flexibility in carrying out the services that match community needs.

"I want a block grant. I badly want a 500,000 to a million dollar [grant] where I can spend it on expanding our RCC, expanding our groups, expanding the scholarships that we provide to the community, essentially recovery starter kits type of stuff, expanding Narcan distribution. There's so many ways in which we could utilize a block grant that isn't afforded to us because everything's a restricted dollar...there's no real opportunity currently for us to just get unrestricted dollars that would go to support the mission and vision that we are going for. So, if I had an opportunity, I just want to stand in front of them and say please guys, we're down here doing all the work. Look at all these people who are either alive or involved because of the work that we've done. I mean, please let us go help more...stop making us do this with one hand tied behind our back" (Region 10 Focus Group).

“
Look at all these people who are either alive or involved because of the work we've done. I mean, please let us go help more...stop making us do this with one hand tied behind our back.
— Region 10 Group
”

“
...the cost for doing an audit is crazy amounts of money... It's over 20 grand [\$20,000] for us to do that audit for our organization. That's like, half a position for us, you know? ...there's a lot of pieces to applying for the federal grant that I feel is not considered for smaller organizations. No amount of spaghetti suppers are going to raise 20 grand for an audit...
— Region 1 Group

In the Region 1 Focus Group, a participant noted that state regulations required highly expensive, mandatory audits upon receiving federal funding—unexpectedly and substantially cutting into their organization's programming. “Another thing that I think is very challenging for small organizations is the requirement for audited financials because the cost of doing an audit is crazy amounts of money... Like, we're going through a one book audit right now because of the federal funds— like through the gopher grants that came through the state was considered federal funding...So, now, we have to go jump a level from using the auditor next door to one who does a one-book audit. It's over 20 grand [\$20,000] for us to do that audit for our organization. That's like half of a position for us, you know? And nothing to show for it except, 'Oh, here's this' so that I can apply for these grants, you know? So there's a lot of pieces to applying for the federal grant that I feel is not considered for smaller organizations. No amount of spaghetti suppers are going to raise 20 grand for an audit, you know what I mean?”

Restrictions in how funding can be used was even reported to impact staff morale. “I do think sometimes the restrictions we have dishearten our case managers and support staff. And it’s like, what am I gonna do? I’m really not helping this person. Like you are, but you’re restricted in what you can do” (Region 6 Focus Group).

It is possible that leaders of these organizations in the ecosystem of recovery misunderstood or misrepresented stipulations associated with federal block grants, state grants, and other localized funding. However, as shown in Table 3, it is problematic that roughly 25% of leaders who partook in the survey did not know if their state had a designated recovery support contact that handles policy and funding matters. Among freestanding/independent RCOs and RCCs, roughly the same portion (23.7%) indicated that their state did not have a designated contact for such issues; having a state contact, or if there is one—making that individual or office unquestionably well known—would be beneficial to clarify any ambiguity in funding restrictions and stipulations.



I do think sometimes the restrictions we have dishearten our case managers and support staff. And it’s like, what am I gonna do? I’m really not helping this person. Like you are, but you’re restricted in what you can do.

— Region 6 Group



TABLE 3: Does your state have a designated recovery support contact(s) that handles policy and funding matters?

	Independent RCOs/RCCs	Other Peer Recovery Organizations	All Organizations
No	N = 18	N = 12	N = 30
%	23.7	14.6	19.0
Yes	N = 40	N = 46	N = 86
%	56.1	52.6	54.4
Don't Know	N = 17	N = 22	N = 39
%	22.4	26.8	24.7
Prefer Not to Answer	N = 1	N = 2	N = 3
%	1.3	2.4	1.9
Total	N = 76	N = 82	N = 158
%	100.0	100.0	100.0

3.3 “My community is not invited to be a part of the conversation”: The Need for Culturally Inclusive Funding Approaches

Organizations in the ecosystem of recovery that support communities made up primarily of people of color face a unique set of challenges in acquiring funding—above and beyond those already described. For example, compared to organizations with majority White community members, fewer organizations with majority community members of color:



Even seemingly statistically small differences, like these, can add up to programmatic challenges in reaching community members as well as sustaining operations.

The leaders of these organizations conveyed that they feel they are either inadequately equipped or largely left out of the mainstream federal funding process. For one organization’s leader who participated in the Native American and Tribal Community listening circle, grant requirements eliminated nearly all potential applicants who provide peer recovery services to Native American community members.

“Tribes don’t have a lot of [data] stored...there isn’t data centers or data collectors for tribes that we could draw this stuff for. Data is so important...Data is a huge barrier for somebody that works. The smaller network of people that are driving change in the community, that are making big impacts...they don’t have the resources to maybe pay a grant writer to come in and do this or pay a consultant to find data or you know what I mean? Let’s say they’re writing a grant or even to conduct a needs assessment as a community, you know what I mean? There’s all these different barriers that I see with an Indian country that the standard for applications or what’s needed for these applications and the people that are going after these fundings. There’s only a few handfuls of people that can actually deliver on what these granting agencies are wanting.”

— Native American and Tribal Community Listening Circle

Cultural disconnects between the federal government and Black, Indigenous and People of Color (BIPOC) recovery communities were portrayed as highly problematic in devising training or even forming new peer recovery funding mechanisms.

“How do you create this space for people of color serving people of color to compete in these spaces? Having technical assistance, having that mentorship...and I have seen in a recent SAMHSA grant—getting to the point where they are defining out ‘what is BIPOC’ and what does that look like when you are going to receive this money; how you will utilize it. Really being able to set the framework for that. In a lot of cases I see people that do not look like me, that do not live in my community, do not serve my community, they are here when the money is available. Then they show up in my community and they do the things they say they were going to do according to whatever the grant was...does not share with my community, my community is not invited to be a part of the conversation about the services or the supports that will be provided in that community.”

— *Black Voices Focus Group*

“Sometimes I am included in the federal monitoring visits because sometimes they come without a translator or other different factors, and I would say about ninety-five percent of our residents are Spanish speaking. Why, as of today’s date, do we still have federal resources that as a requirement they should — if you are working with these residents, you should not be surprised when you show up speaking English and then group participants feel intimidated because they don’t speak the same language as that person. And the times when you do bring an interpreter or translator information goes missing — information goes missing because of the translation, the words, the slang and it’s something they don’t understand. It’s not about translating a manual. It’s not about having an interpreter. It’s that you should not be the person that is visiting, as the resource, because from your skin color to everything it’s saying, ‘the White folk is here to deal with the Hispanic, Latino, Boricua’ and to today’s date we have had situations in which we have had to point out, even during trainings, that we in fact have Latino training resources. But because a person is North American, White, not Spanish speaking, we have to adapt a whole training because of that person. What message are we sending the community? That one has to be White and English- speaking to be productive? And it’s really sad because it really strains that relationship.”

— *Latinx 2 Focus Group*

Equally as, or perhaps more, important are funding mechanisms that are perceived as not culturally inclusive. This impacts organizations’ abilities to fulfill their organizational visions even if they are able to acquire funding. This was most evident when hearing from leaders of organizations whose community members are mostly Native Americans; the clinical and stigmatizing language of requests for proposals (RFPs) at the federal level could deter organizations from even considering applying for it.

“Native Americans, we operate on the medicine wheel concept. They’re split into four: spiritual, physical, mental, and emotional... But yet how do you speak spiritual language and evidence-based practice?...Let’s say if I wanted to, like how I do before a lot of talks or whatever to calm myself down, I smudge. That’s not evidence-based. If I am stressed or worried and I jump in a sweat lodge, and whatever like that and I come out, that’s not evidence-based. Let’s see here. Not only that, but the language that’s used in some of these granting agencies when I read RFPs talking about ex-con or addict or whatever, this is stigmatizing language coming straight from granting agencies. Sometimes I cringe when I’m reading some of these RFPs and it’s like I have to contort myself to this system if I want funding.”

— Native American and Tribal Community Listening Circle

3.4 “Keep the lights on”: Diversifying Funding to Sustain

Despite the barriers that organizations in the ecosystem of recovery face when trying to acquire federal and state funding, they persist in seeking funding from a wide range of sources to continue providing peer recovery services to their community members. “A lot of that, it’s what I call ‘keep the lights on’ funding. It doesn’t do much, but it’ll-- it keeps some of the lights on in the building...What I really want to pay for is more recovery coaches...So, it’s always frustrating...It’s just how restricted those large grants are” (Region 4 Focus Group).

3.4.1 Diversifying Funding Streams

Organizations in the ecosystem of recovery are realistic about their limited capacity to devote time to acquiring a wide variety of funding; their priorities are providing services for individuals living with SUD. The need to diversify funding sources is in greater need among freestanding/independent RCOs and RCCs than other types of peer recovery organizations; current budgets for about 74% of freestanding/independent RCOs and RCCs were estimated to have no federal funding compared to roughly 60% of other organizations. Not surprisingly, freestanding/independent RCOs and RCCs were much more reliant on state funding and private donations to maintain operations.

For many smaller organizations, guidance from SAMHSA on how to acquire alternative funding would help increase the chances of long-term viability. “...if SAMHSA was to possibly put a toolkit together with templates and samples...those 30-second features for folks who’ve never gone and asked a municipality for money before, or a foundation, this is what a great introductory letter looks like. And you just fill in your agency name and all that. Or, this is how you would approach a town or go to a town meeting or however your municipality votes to ask for money...But if you could put maybe part of that packet, just samples about how do I go ask people for money? How do I get that little community investment? Because I’ve never done it, I’m not comfortable doing it. I have no idea what to say or how to nurture and cultivate a

“A lot of that, it’s what I call ‘keep the lights on’ funding. It doesn’t do much, but it’ll-- it keeps some of the lights on in the building...What I really want to pay for is more recovery coaches...So, it’s always frustrating...It’s just how restricted those large grants are.”

— Region 4 Group

“
I have no idea what to say or how to nurture and cultivate a relationship between a potential donor if it's a one-time or a long-time donor relationship. So, I think that kind of support would also help with the sustainability issue post-funding.

— Region 4 Group

relationship between a potential donor if it's a one-time or a long-time donor relationship. So, I think that kind of support would also help with the sustainability issue post-funding” (Region 4 Focus Group).

Given that most organizations in the ecosystem of recovery are not “flush” with funding, acquiring new, large sums comes with challenging budgeting situations—especially if the funding has not yet come through. “This is not the norm, to get \$1 million worth of grants in a few months, but we are super excited...However, we were told we received a grant from a local university, and that was 10 and a half months ago...We are superfunded for myself and some peer recovery specialists, as well. However, because we're still fairly new, the nest egg is now bare. Some of us have worked as a volunteer...when we did finally get that reimbursement, I was able to catch up. But not everybody can afford to

do something like that...I've heard that's how it goes with grants. That's why you should be having multiple fundraisers so that you can build that nest egg in the event something does go awry with the grant, or something gets questioned. Again, because we're a small staff of just five people, you can only spread yourself so thin when you're talking about self-care and things like that. And we are providing peer services, so you don't want to get too burned out with all of that. But like I said, a lot of us have given a lot of our hearts and from our pocketbooks” (Region 5 Focus Group).

Unfortunately, leaders of such organizations are used to working for free, or spending their personal money to keep peer recovery services afloat; without consistent streams of funding available—even if large grants are acquired—this pattern will likely continue.

3.4.2 Sustainability

Even with leaders' best efforts to diversify their funding streams, the ability to sustain operations—and continue to exist—is a constant threat to organizations in the ecosystem of recovery. “I do want to reiterate what [she] said about the 3 and 5 year timeframe. That is one of our biggest concerns, the sustainability piece. It's great we can implement these services. Yay, we get to hire new people! But really gotta do some work on the backend to make sure we can keep going after those 3 years. I'd love to see more of the 5 year timeframes for recovery services” (Region 6 Focus Group).

Individuals driving the missions of such organizations did not get into providing peer recovery support to generate revenue. However, they have come to realize that they need consistent funding to maintain operations so that they can continue to meet the needs of their communities.

“
I've heard that's how it goes with grants. That's why you should be having multiple fundraisers so that you can build that nest egg... a lot of us have given a lot of our hearts and from our pocketbooks.

— Region 5 Group

“
It's great we can implement these services...But really gotta do some work on the backend to make sure we can keep going after those 3 years. I'd love to see more of the 5 year timeframes for recovery services

— Region 6 Group

“It’s also that sustainability part of it. Our services here are free. We do have office space we rent out, but that doesn’t really amount to anything...SAMHSA, those grants could be more lenient and understanding for the sustainability of these community-based programs. We are with people for the long-term. We have people that our organization has been open for 12 years, and we have people that have been coming that whole time to take advantage of our services here. Their monetary donations, that’s not what we’re getting out of it, we’re making a better community” (Region 3 Focus Group).

In the case of Puerto Rico, diversifying funding—beyond federal funds—offers little security and thus the need for federal funding is essential to maintain operations and provide peer recovery services.

“*...SAMHSA, those grants could be more lenient and understanding for the sustainability of these community-based programs. We are with people for the long-term...*”
— Region 3 Group

“Funds don’t really exist at the state level. Puerto Rico is legally bankrupt...It’s been bankrupt for many years, therefore...almost 80% of the funds—of the services—come from federal funding. Therefore, the only places being supported by state funding are hospitals, meaning major services. Everything else is from federal funds, and even though we are grateful for it, it also carries great risk, because if at any moment those funds stop existing, then services would shut down.”
— Latinx 1 Focus Group

Although some organizations in the ecosystem of recovery were able to dramatically diversify their funding—whether through partnering with a hospital system or getting donations from large corporations—most rely on the goodwill of small donors and any possible state and federal funding.

4. Policy Recommendations and Conclusion

I. Reduce the complexity of the grant process and provide training and technical assistance.

A key barrier outlined in the findings from Section 3.1 suggest that **recovery organizations perceive and/or experience federal grant applications as complex and express the need for training and technical assistance around the federal grant-writing process.** While we understand the tension funders experience in trying to balance the need for simpler applications and reports with the need to provide detailed information to elected officials about how public funding is spent, we believe there are opportunities for addressing the difficulties expressed by respondents in this assessment. Recommendations include:

- A. Provide a recovery-focused grant writing series to maximize the grant writing success of organizations in the recovery ecosystem. Components could include: how to identify grants, how to ensure grants selected are a good fit for your recovery organization, how to collaborate with other organizations to increase your success, and templates for grant writing. This training could further include organizations that have successfully won SAMHSA grants sharing core lessons learned and approaches.
- B. Host an intensive learning collaborative for organizations that unsuccessfully applied for grants. This could include tailored information on why their grant was not successful, ways they could improve for future grants, and webinars that prioritized issues repeatedly seen across unsuccessful grant applications (providing examples of successful applications they could learn from).
- C. Develop a central system for recovery organizations to apply for grants that would include people to contact for grant application questions and/or for assistance in uploading data. Allow each organization to have a unique profile with customized login information where they could upload key documents that could be updated and re-utilized rather than being repeatedly uploaded/duplicated for each new grant.
- D. Review a sample of existing requests for proposals for grants for complex wording and confusing directions and streamline and/or reformat the text using plain English. Provide a brief for each grant outlining the key points and requirements with examples.

II. Opportunities to maximize the impact of funding for recovery organizations

As the findings from Section 3.2 show, **recovery organizations suggested a significant shift in how the recovery ecosystem is funded.** Recovery organizations suggested greater flexibility in the allowable use of funds, a longer time period in which to spend the funds, more information about recovery funding opportunities, and additional resources for community recovery organizations. Recommendations include:

- A. Require greater transparency in how states distribute federal dollars. Develop a better needs assessment process for states to use to determine how and where to allocate resources.
- B. Issue guidance to States in both the State Opioid Response and Substance Abuse Block Grant programs defining organizational characteristics, governance, and service/support orientation for what constitutes a community-based recovery support service. SAMHSA has provided such definitions previously in the FY2022 and FY2023 budget requests to Congress for a recovery set-aside in the block grant.
- C. Review state/regional data and prioritize community needs based on existing recovery resources/gaps.
- D. Build capacity of state agencies to support the recovery community and ensure each state office has a clear point of contact that proactively engages recovery programs across the state.
- E. Provide guidance and case studies to states that show how facilitating organizations can be used to develop robust recovery community ecosystems by allowing dollars to flow to the entities on the ground that might otherwise be boxed out of state and federal funding opportunities due to bureaucracies and complexities of funding applications.

III. Develop inclusive and culturally responsive funding approaches

A key barrier outlined in the findings from Section 3.3 detailed the **concerns expressed from organizations led by and/or serving historically marginalized communities about being excluded from a funding network that can be based on relationships and experiences within the dominant culture**. For historically underserved communities, data may be lacking, the design of the grant may not align with their communities' needs, and/or may not be culturally responsive in other ways. Recommendations offered to address this include:

- A. Engage diverse community members to better understand the gaps in mainstream funding applications and outline innovative strategies for developing inclusive and culturally responsive funding approaches. Bridge the gap in language and understanding between members of the recovery community who represent diverse populations and federal and state authorities who develop grant applications by funding a thought experiment in which the recovery community members would design their ideal grant application and present that application to the government officials. Compare and contrast how the community-designed application differs from the typical application. Integrate elements of the community-designed application in future funding announcements.
- B. Provide additional support and prioritize grant funding for organizations that predominantly serve historically marginalized communities.
- C. Expand the scope of funded services beyond those that are commonly called evidence-based to ensure culturally responsive services are eligible for funding. Ensure that the scoring rubric for grants aligns with this expanded scope.
- D. Ensure SAMHSA and state authorities have culturally-responsive staff members and grant reviewers who can prioritize and address the needs of non-English speaking and/or BIPOC-focused organizations in the ecosystem of recovery.

IV. Support expanded recovery services based on community needs and sustainability

A key barrier outlined in the findings from Section 3.3 detailed the **concerns expressed from organizations led by and/or serving historically marginalized communities about being excluded from a funding network that can be based on relationships and experiences within the dominant culture.** For historically underserved communities, data may be lacking, the design of the grant may not align with their communities' needs, and/or may not be culturally responsive in other ways. Recommendations offered to address this include:

- A. Streamline reporting requirements with up-front training and/or templates provided for reporting to reduce the administrative burden. Minimize data collection and reporting to that which is truly necessary to demonstrate appropriate use of funds. Do not require recovery service grantees to utilize the same forms and reporting mechanisms as those grantees that provide clinical services.
- B. Provide small-scale funding streams to enable more independent recovery organizations to benefit from federal support, similar to the ways that small businesses are eligible for distinct federal contracts in other sectors.
- C. Provide a training on the importance of funding diversification to support organizational sustainability, include examples of successful recovery organizations sustainability approaches and a resource list of funding sources that support substance use RSS.

Conclusion

RCOs and RCCs face considerable barriers to accessing and sustaining funding, many of which relate to limited organizational capacity. Systemic barriers exist in the lack of culturally responsive opportunities for recovery organizations, leading to even more challenges for organizations that serve minoritized communities to receive funding.

Nevertheless, opportunities exist to address these issues through technical assistance, review and modification to funding proposals to make them more accessible and culturally responsive, and greater access to information on funding resources. By exploring these and other suggestions to reduce the barriers outlined in this report, recovery organizations will be better able to achieve the vital mission of supporting people in recovery from SUDs.

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5. Contributions

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Joe Powell, President & CEO, Association of Persons Affected by Addiction

Gabrielle Rodriguez, Founder & Co-Creator, La Conexion

Flo Stein-Bolton, Former Deputy Director, North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Mark Stringer, Former Director, Missouri Department of Mental Health

Pata Suyemoto, Training/Program Director and Consumer Advocate, National Asian American Pacific Islander Mental Health Association

Melanie Whitter, Deputy Executive Director, NASADAD

Greg Williams, Managing Director, Third Horizon Strategies

* J. Alegre began participating in the SME panel in July 2022.

† K. Harper left employment at Faces and Voices of Recovery in April 2022 and Patty McCarthy replaced her on the SME Panel after that time.

** Due to unexpected circumstances, K. Coyhis was unable to continue participation in the SME Panel after May 2022.

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6. Appendix

6.1 Acronyms and Key Terms

Ecosystem of Recovery – Recovery Community Organizations, Peer Recovery Organizations, or any other types of organizations that provide recovery support services, pertaining to substance use disorder.

501(c)(3) – IRS Non-Profit Tax-Exempt Status

AAPI/NHPI – Asian American Pacific Islander/ Native Hawaiian Pacific Islander

ARCO – Association of Recovery Community Organizations

ATTC – Addiction Technology Transfer Center

BCOR Grants – Building Communities of Recovery

BIPOC – Black, Indigenous, People of Color

CDC – Centers for Disease Control and Prevention

COVID – Coronavirus disease

FAVOR – Faces and Voices of Recovery

GPRA – Government Performance and Results Act

HHS – Health and Human Services

HRSA – Health Resources and Services Administration

IRB – Institutional Review Board

LGBTQIA+ – Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and/or Asexual

MOUD – Medications for Opioid Use Disorder

NTAC – National Technical Assistance Center

OORP – Opioid Overdose Recovery Program

ORN – Opioid Response Network

PR CoE – Peer Recovery Center of Excellence

PRSS – Peer Recovery Support Specialist

RCO – Recovery Community Organization

RCC – Recovery Community Center

RFA – Request for Application

RFP – Request for Proposal

SABG – Substance Abuse Block Grant

SAMHSA – Substance Abuse and Mental Health Services Administration

SOR – State Opioid Response

SOR2 – State Opioid Response 2 year grant

SME Panel – Subject Matter Expert Panel

SSA – Single State Authority

SUD – Substance Use Disorder

TTA – Training and Technical Assistance

Peer Recover Center of Excellence Regions

(Defined by the U.S. Department of Health and Human Services)

Region 1

Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Region 2

New Jersey, New York, Puerto Rico, U. S. Virgin Islands

Region 3

Delaware, Maryland, Pennsylvania, Virginia, West Virginia, District of Columbia

Region 4

Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee

Region 5

Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin

Region 6

Arkansas, Louisiana, New Mexico, Oklahoma, Texas

Region 7

Iowa, Kansas, Missouri, Nebraska

Region 8

Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming

Region 9

Arizona, California, Hawaii, Nevada, American Samoa, Federated States of Micronesia, Guam, Marshall Islands, Republic of Palau, Northern Mariana Islands

Region 10

Alaska, Idaho, Oregon, Washington

6.2 Survey Questions

Needs Assessment to Optimize Access to Funding for Organizations in the Ecosystem of Recovery Across the US

Principal Investigators	<ul style="list-style-type: none">• Tyler W. Myroniuk (University of Missouri-Columbia)• Enid Schatz (University of Missouri-Columbia)• Laurie Krom (University of Missouri-Kansas City)
Funding Source	<ul style="list-style-type: none">• Substance Abuse and Mental Health Services Administration (SAMHSA)• Institutional Review Board Number: 2080542 MU

Welcome!

As a leader of your organization, we would like to understand barriers your organization faces and successes your organization has had in acquiring federal and state funding. We are interested in hearing from organizations such as Recovery Community Organizations, Peer Recovery Organizations, or other types of organizations that provide recovery support services—any and all of those that are part of the “ecosystem of recovery.” With your help, we have the unique opportunity to understand how organizations such as yours are funded and to develop practical suggestions to offer SAMHSA in order to inform change. By participating, you will be providing input so that your organization’s needs are represented in these efforts!

We invite you to take part in this survey—which will take about 10 minutes—because you were identified as a leader of your organization. In this needs assessment, you will be asked to describe your organization’s challenges and successes in acquiring funding for recovery support services.

Data Safety and Security

All responses are confidential. We will give your records a code number and they will not contain your name or other personal information that could identify you or your organization. The code number that connects your name to your information will be kept in a separate, secure location housed on University of Missouri secure servers. Information that could identify you will be removed from your responses so no one will know that it belongs to you. When we present our final report to SAMHSA and if we publish the results of this study or present them at scientific meetings, we will NOT use your name or other personal information. The results of this survey will be shared with you, in aggregate, so you have access to information that included your contributions and data.

*In case the term “ecosystem of recovery” is new to you, here are some informative links (<https://recoverycenterofexcellence.org/learn/ecosystem-recovery>, [Building-Recovery-Ready-Communities-The-Recovery-Ready-Ecosystem-Model-and-Community-Framework.pdf](#) (researchgate.net)).

You can click the back button on your browser, to continue with the survey if you follow either of these links.

Next Steps

T1. If you are interested in participating in this survey, please respond:

- I would like to continue
[PROCEED TO T2]
- I don't want to participate in this survey
[THANK YOU FOR YOUR TIME SCRIPT]

T3. Which term best fits how you characterize your organization?

- | | |
|---|---|
| <input type="checkbox"/> 0) Recovery Community Organization | <input type="checkbox"/> 7) Recovery High School |
| <input type="checkbox"/> 1) Peer Recovery Organization | <input type="checkbox"/> 8) Collegiate Recovery Program |
| <input type="checkbox"/> 2) Recovery Community Center | <input type="checkbox"/> 9) Recovery Housing |
| <input type="checkbox"/> 3) Recovery Coalition | <input type="checkbox"/> 10) Other (please fill in the blank in the next prompt): _____ |
| <input type="checkbox"/> 4) Recovery Clubhouse | <input type="checkbox"/> 99) Prefer Not to Answer |
| <input type="checkbox"/> 5) Recovery Café | |
| <input type="checkbox"/> 6) Sober Support Group | |

T4. What is your organization's name? (This will not be reported outside of the study)

- [OPEN ENDED]: _____

A. Background Information

To begin this survey, we would like to know more information about your organization, the people you serve, and programs you offer.

1. What is your role within your organization?

- | | |
|--|--|
| <input type="checkbox"/> 0) CEO | <input type="checkbox"/> 4) Program Manager |
| <input type="checkbox"/> 1) Director | <input type="checkbox"/> 5) Other (please fill in the blank in the next prompt): _____ |
| <input type="checkbox"/> 2) Executive Director | <input type="checkbox"/> 99) Prefer Not to Answer |
| <input type="checkbox"/> 3) President | |

2. Approximately what percentage of your staff have lived experience of recovery from a substance use disorder or from substance use challenges?

- | | |
|---|---|
| <input type="checkbox"/> 0) 0% | <input type="checkbox"/> 88) Don't Know |
| <input type="checkbox"/> 1) 1% to 50% | <input type="checkbox"/> 99) Prefer Not to Answer |
| <input type="checkbox"/> 2) 51% to 100% | |

3. Which US state/territory is your organization located in?

- [DROP DOWN MENU]

4. Which category best describes the location of your organization?

- 0) Rural
- 1) Suburban
- 2) Urban
- 3) Other (please fill in the blank)
- 88) Don't Know
- 99) Prefer Not to Answer

5. For whom does your organization primarily focus on offerings for: (select all that apply)

- 0) All people
- 1) People experiencing homelessness
- 2) People with disabilities
- 3) People who identify as lesbian, gay, bisexual, transgender, queer, intersex, and/or asexual (LGBTQIA+)
- 4) People who are justice-involved (including those who are currently or previously incarcerated)
- 5) Black, Indigenous, and People of Color (BIPOC)
- 6) Women
- 7) Men
- 8) Youth
- 9) Recovery Community at Large
- 10) Other (please fill in the blank in the next prompt): _____
- 88) Don't Know
- 99) Prefer Not to Answer

6. Does your organization offer any of the following? (Select all that apply)

- 0) Recovery Coaching
- 1) Recovery Advocacy
- 2) All Recovery Meetings
- 3) Mutual-aid Meetings
- 4) Smoking Cessation
- 5) Technology/Internet Access
- 6) Volunteering
- 7) Narcan/Naloxone Training
- 8) Recreational Activities
- 9) Legal Assistance
- 10) Employment Assistance
- 11) Family Support Services
- 12) Peer-facilitated Support Groups
- 13) Housing Assistance
- 14) Basic Needs Assistance
- 15) Education Assistance
- 16) Mental Health Support
- 17) Childcare Services
- 18) Financial Services
- 19) Expressive Arts
- 20) Health/Nutrition/Exercise
- 21) Voter Registration
- 22) Public Education
- 23) Transportation
- 24) Wellness Activities
- 25) Drug-free Social Activities
- 26) Other (please fill in the blank in the next prompt): _____
- 88) Don't Know [CANNOT SELECT ANY OTHER RESPONSE]
- 99) Prefer Not to Answer [CANNOT SELECT ANY OTHER RESPONSE]

7. With your best guess, approximately what percentage (%) of your participants/members are Hispanic/Latinx, regardless of other racial identities (Black/African American, White, etc.)?

- 0) Hispanic/Latinx _____%
- 88) Don't Know [CANNOT SELECT ANY OTHER RESPONSE]
- 99) Prefer Not to Answer [CANNOT SELECT ANY OTHER RESPONSE]

8. With your best guess, what is the approximate demographic breakdown of your participants/members regardless of whether they may also identify as Hispanic/Latinx? Please write a percentage value next to each racial identity, starting with "Black/African American". The survey has a running total for you to view. If your scores do not add up to 100%, the survey will provide a warning before you proceed. If you make a mistake, you can go back and change a reported percentage.

- 0) Black/African American _____%
- 1) Asian American/Pacific Islander _____%
- 2) Native American/Alaska Native _____%
- 3) White _____%
- 4) Other (please fill in the blank) _____%
- 88) Don't Know _____%
- 99) Prefer Not to Answer [CANNOT SELECT ANY OTHER RESPONSE]

9. What language does your organization typically conduct its operations in? (Select all that apply)

- 0) English
- 1) Spanish
- 2) Other (please fill in the blank in the next prompt): _____
- 88) Don't Know [CANNOT SELECT ANY OTHER RESPONSE]
- 99) Prefer Not to Answer [CANNOT SELECT ANY OTHER RESPONSE]

10. In a typical week, roughly how many community members (total number of unique individuals) do you serve?

- 0) 1-29
- 1) 30-49
- 2) 50-99
- 3) 100-199
- 4) 200-499
- 5) 500-999
- 6) 1000+
- 88) Don't Know
- 99) Prefer Not to Answer

11. What year was your organization founded?

- 0) (year drop down menu)
- 73) Before 1950
- 88) Don't Know
- 99) Prefer Not to Answer

4. Does your organization already have a 501(c)(3) IRS tax exemption?

- 0) No [PROCEED TO Q12B]
- 1) Yes [SKIP TO Q13]
- 88) Don't Know [SKIP TO Q13]
- 99) Prefer Not to Answer [SKIP TO Q13]

12b. Is your organization seeking a 501(c)(3) IRS tax exemption?

- 0) No
- 1) Yes
- 88) Don't Know
- 99) Prefer Not to Answer
- 13. Please choose one of the following to describe your organization:
 - 0) Our organization is an independent/"free standing" recovery organization
 - 1) Our organization is a distinct program of a larger umbrella organization that provides administrative and/or operational supports
 - 2) Our organization primarily focuses on substance use disorder TREATMENT and also provides recovery support services
 - 3) Other (please fill in the blank in the next prompt): _____
 - 88) Don't Know
 - 99) Prefer Not to Answer

13. Please choose one of the following to describe your organization:

- 0) Our organization is an independent/"free standing" recovery organization
- 1) Our organization is a distinct program of a larger umbrella organization that provides administrative and/or operational supports
- 2) Our organization primarily focuses on substance use disorder TREATMENT and also provides recovery support services
- 3) Other (please fill in the blank in the next prompt): _____
- 88) Don't Know
- 99) Prefer Not to Answer

14. Is your organization a member of the Association of Recovery Community Organizations (ARCO)?

- 0) No, we do not have ARCO membership
- 1) Yes, we have ARCO membership
- 88) Don't Know
- 99) Prefer Not to Answer

B. Funding

This section is about your organization's current funding and experiences in acquiring funding.

1a. Has your organization ever applied for funding directly from a FEDERAL government agency or department?

- 0) No [SKIP TO Q2A] 88) Don't Know [SKIP TO Q2A]
 1) Yes [PROCEED TO Q1B] 99) Prefer Not to Answer [SKIP TO Q2A]

1b. Has your organization been successful in an application and acquired funding directly from a FEDERAL government agency or department?

- 0) No 88) Don't Know
 1) Yes 99) Prefer Not to Answer

2a. Has your organization ever applied for funding directly from a STATE government agency or department?

- 0) No [SKIP TO Q3] 88) Don't Know [SKIP TO Q3]
 1) Yes [PROCEED TO Q2B] 99) Prefer Not to Answer [SKIP TO Q3]

2b. Has your organization been successful in an application and acquired funding directly from a STATE government agency or department?

- 0) No 88) Don't Know
 1) Yes 99) Prefer Not to Answer

3. We would like to know the approximate percentage breakdown of where your organization's funding comes from. Please write a percentage value next to each relevant funding source. The survey has a running total for you to view. If your scores do not add up to 100%, the survey will provide a warning before you proceed. If you make a mistake, you can go back and change a reported percentage.

- 0) Federal government (directly from a federal agency or department) _____% 5) Individual donations _____%
 1) State government (directly from a state agency or department) _____% 6) Revenue stream generated by your organization _____%
 2) County government _____% 7) Other: _____%
 3) Municipal government _____% 88) Don't Know _____%
 4) Business donations _____% 99) Prefer Not to Answer [CANNOT SELECT ANY OTHER RESPONSE]

4. Please rank the top 3 barriers to acquiring FEDERAL funding, in order of the most significant barrier (ranked #1) to the third most significant barrier on this list (ranked #3):

- 0) ____ Complicated applications 4) ____ We don't have someone with expertise in federal grant applications
 1) ____ Application and reporting requirements do not fit the peer recovery model 5) ____ We don't have enough time to apply for funding
 2) ____ Reimbursement models that are more appropriate for clinical settings and services 6) ____ The federal grant system is difficult to navigate
 3) ____ Funding goes to clinics or other types of organizations 7) ____ Too much competition with other organizations

- 8) ___ Insufficient funding opportunities
- 9) ___ Duration of funding is too short
- 10) ___ Unrealistic cash match requirements
- 11) ___ We don't know about federal funding opportunities
- 12) ___ Our organization is ineligible to apply for federal funding
- 88) Don't Know [CANNOT SELECT ANY OTHER RESPONSE]
- 99) Prefer Not to Answer [CANNOT SELECT ANY OTHER RESPONSE]

5. Please rank the top 3 barriers to acquiring STATE funding, in order of the most significant barrier (ranked #1) to the third most significant barrier on this list (ranked #3):

- 0) ___ Complicated applications
- 1) ___ Application and reporting requirements do not fit the peer recovery model
- 2) ___ Reimbursement models that are more appropriate for clinical settings and services
- 3) ___ Funding goes to clinics or other types of organizations
- 4) ___ We don't have someone with expertise in state grant applications
- 5) ___ We don't have enough time to apply for funding
- 6) ___ The state grant system is difficult to navigate
- 7) ___ Too much competition with other organizations
- 8) ___ Insufficient funding opportunities
- 9) ___ Duration of funding is too short
- 10) ___ Unrealistic cash match requirements
- 11) ___ We don't know about state funding opportunities/We don't have knowledge of the state office where we might find more information about funding for recovery support services
- 12) ___ Our organization is ineligible to apply for state funding
- 13) ___ Our state does not have a budget line for funding recovery organizations
- 88) Don't Know [CANNOT SELECT ANY OTHER RESPONSE]
- 99) Prefer Not to Answer [CANNOT SELECT ANY OTHER RESPONSE]

6. How supportive is your Single State Agency (SSA) (e.g., Department of Health and Social Services, Division of Substance Abuse and Mental Health, Department of Behavioral Health, Department of Health and Welfare, etc.) in finding funding for recovery organizations (state/federal/private)?

- 0) Very helpful
- 1) Helpful
- 2) Neither helpful nor unhelpful
- 3) Unhelpful
- 4) Very unhelpful
- 88) Don't Know
- 99) Prefer Not to Answer

7. Does your state have a designated recovery support contact(s) that handles policy and funding matters?

- 0) No
- 1) Yes
- 88) Don't Know
- 99) Prefer Not to Answer

8. Has your organization collaborated with other organizations regarding funding?

- 0) No
- 1) Yes
- 88) Don't Know
- 99) Prefer Not to Answer

9. Does your organization have any formal partnerships with other organizations regarding funding?

- 0) No
- 1) Yes
- 88) Don't Know
- 99) Prefer Not to Answer

10. In which ONE of the following areas do you believe support, training, or technical assistance would improve your opportunities to receive federal and/or state funding?

- 0) Information Technology (IT)
- 1) Administrative support
- 2) Data Collection
- 3) Grant Writing
- 4) Other (please fill in the blank in the next prompt): _____
- 88) Don't Know
- 99) Prefer Not to Answer

11. In the form of a few sentences or a paragraph, please explain more about the most significant barriers to acquiring funding for your organization.

[OPEN ENDED]

12. In the form of a few sentences or a paragraph, please explain more about the most significant successes your organization has had in acquiring federal and/or state funding.

[OPEN ENDED]

C. Follow-up

There will be a second part of this needs assessment where we conduct focus groups/ community conversations/listening circles, where leaders of organizations in the ecosystem of recovery will come together to discuss barriers to and successes in acquiring funding in a group setting (online and/or in-person).

1. Would you like to participate in a focus group/community conversation/listening circle with other leaders?

These conversations will last between 60 and 90 minutes and each participant will be compensated \$50 for their time. (Depending on how many responses we get, we may not be able to include everyone who wants to participate in order to ensure distribution across administrative regions).

0) No [SKIP TO END THANK YOU SCRIPT]

1) Yes [PROCEED TO Q2]

2. Please provide your preferred email address so that we can follow-up with you. (This will not be used or reported outside of the study).

[OPEN ENDED]

3. Please provide your name so that we can follow-up with you. (This will not be reported outside of the study).

[OPEN ENDED]

CLICK TO FINISH SURVEY [END THANK YOU SCRIPT]

[THANK YOU FOR YOUR TIME SCRIPT]

We appreciate that you considered participating in this needs assessment. Thank you for your time.

[END THANK YOU SCRIPT]

Thank you for participating in this needs assessment. Your responses will help inform change by offering insight into the barriers to and successes in acquiring funding, which will be reviewed by SAMHSA.

6.3 Focus Group Guide

Welcome everyone and thank you for taking the time to come here and share your experiences on your organizations successes in acquiring funding, as well as sharing about the barriers your organization has faced.

My name is _____ and I am a _____ at _____. I'll be facilitating this focus group/community conversation/listening circle.

With your help, we have the unique opportunity to understand experiences related to funding in organizations such as yours and to develop practical suggestions to offer SAMHSA to inform change. By participating today, you will be providing input so that your organization's needs are represented in these efforts!

Today's session will last between 60 and 90 minutes. As the facilitator, I will ask the group a series of questions that are meant to spur discussion among all of you. My role is to ensure that we maximize what we can learn about your organizations' experiences with funding, so I will ask about a number of topics and sometimes push you to expand your answers. We will have about 10 minutes to discuss each question that I ask. If you don't feel comfortable discussing a topic, that is OK! If you already gave your thoughts on a question, please allow a few seconds for others to join in and offer theirs.

This focus group will be recorded so that we can transcribe and analyze your discussion. We would appreciate it if you could turn on your video to help us understand non-verbal responses—such as nodding heads and expressions—to the topics we discuss. Although we are on Zoom, we are hoping to create similar conditions as if we were all in person. For this reason, we would appreciate it if you would only use the chat function for technical support questions. Please feel free to use the hand-raise symbol if you find that easier to jump into the discussion.

All responses are confidential. Each participant will be assigned an ID number so that the transcription and analyses will not contain your name or other personal information that could identify you or your organization. The ID number that connects your name to your information will be kept in a separate, secure location housed on University of Missouri secure servers. Information that could identify you will be removed from your responses so no one will know that it belongs to you. When we present our final report to SAMHSA and if we publish the results of this study or present them at scientific meetings, we will NOT use your name or any other information about you or your organization. The results of this focus group will be shared with you, in aggregate, so you have access to what we learned across all the focus groups.

Instructions for Facilitator

Here is the document legend for questions, prompts, and notes for the facilitator.

Questions are **bolded regular text** (can number later);

prompts in *italics*;

facilitator notes **highlighted**

Introductions

Before we begin, I'd like to take this opportunity to go around the Zoom Room so that we can introduce ourselves. Please state your name, role, and organization you are representing.

[Before proceeding to the formal questions, ask:]

What questions do you have before we begin?

Question 1

To start, let's go around and share some of your successes in acquiring funding for your organization in the last few years.

- | | |
|--|--|
| <input type="checkbox"/> Had you received this type of funding before? | <input type="checkbox"/> What prompted you to apply for this funding? |
| <input type="checkbox"/> Who, on your team, was very helpful in putting together a winning application? Don't be shy in naming yourself! | <input type="checkbox"/> How challenging or easy was the process of applying for and receiving this funding? |
| <input type="checkbox"/> What do you think made you successful? | <input type="checkbox"/> Do others agree/disagree? WHY? |

***[START FOR SAMHSA REGION FOCUS GROUPS]

Question 2

- | | |
|---|--|
| <input type="checkbox"/> How do you think that your geographic location affects the application and awards process for your organization? | <input type="checkbox"/> What preferential treatment, if any, do you observe in the application process? |
| <input type="checkbox"/> What specific issues hinder or enhance that process? | <input type="checkbox"/> What about in the awards process? |
| | <input type="checkbox"/> Do others agree/disagree? WHY? |

(If there is a strong intersection between geography and the identities of community members being served that emerges, feel free to explore this).

[END]

**[START FOR POPULATION/IDENTITY-SPECIFIC FOCUS GROUPS ONLY]

Question 2

How do you think that your organization predominantly serving [insert sub-population name] affects the application and awards process for your organization?

- | | |
|---|--|
| <input type="checkbox"/> What specific issues hinder or enhance that process? | <input type="checkbox"/> observe in the application process? |
| <input type="checkbox"/> What preferential treatment, if any, do you | <input type="checkbox"/> What about in the awards process? |
| | <input type="checkbox"/> Do others agree/disagree? WHY? |

(If there is a strong intersection between the identities of community members being served and geography that emerges, feel free to explore this).

[END]

Question 3

- | | |
|---|--|
| <input type="checkbox"/> What would you most like SAMHSA to know in order to improve your chances of acquiring funding? | <input type="checkbox"/> What types of funding opportunities would best suit your organization? Why? |
|---|--|

(Get them to compare, say what they are looking for in terms of topic, time frame for RFA/FOA, how large a proposal, how much money, etc.)

- Do others agree/disagree? WHY?

Question 4

Now let's turn to the flip-side of all of this. Let's go around and share the barriers you or your organization have faced, and continue to face, in acquiring funding for your organization.

- How much time does applying for one grant take you? How much time do you spend overall?
- How many grant opportunities can you apply for in a year, given the time it _____ takes?
- Which barriers feel manageable with additional support?
- Which barriers feel insurmountable?
- What factors do you consider when you prioritize which grant opportunities to apply for? (amount, team/expertise, type of services enhanced)
- Do others agree/disagree? WHY?

Question 5

- What would you most like SAMHSA to know about the difficulties you face in acquiring funding?
- Probe for structures related to their organization, and their state/federal funding mechanisms
- What are some recommendations for funding assistance/opportunities needed to sustain the recovery ecosystem?
- What would you really like to do but don't have the funding—or the funding doesn't exist—to do it?
- Do others agree/disagree? WHY?

[IF THERE IS TIME REMAINING, ASK THESE ADDITIONAL QUESTIONS]

Question 6

- What type of resources or training would really help your organization get more funding?
 - What specific issues hinder or enhance that process?
- Webinars/training/technical assistance or other consultation from SAMHSA/your state/other organizations?
 - Database or email of funding opportunities?

(Make sure to follow up on any barriers that feel manageable with additional support to find out what kind of support wasn't already mentioned.)

- Do others agree/disagree? WHY?

Question 7

When you were awarded a grant, what kind of an impact did it have on your organization?

- Were you able to hire new staff?
- Were you able to help more community members?
- Were you able to expand your offerings of recovery support services?
- Were you able to buy new equipment or upgrade your space?
- Were you able to help more community members?
- Were you able to expand your offerings of recovery support services?
- Were you able to buy new equipment or upgrade your space?

Question 8

- What are the factors that give your organization an advantage when applying for funding?

(ASK AFTER FINISH ANSWERING ADVANTAGE: “What about factors that give your organization an DISADVANTAGE when applying for funding?”)

- type of clientele, aims of organization, etc

- How is this different for federal vs state funding?
- What kinds of structural or political factors How do you navigate things like “old boys’ club”, if you feel that exists?
- What about state politics? How is that a factor or not?
- Do others agree/disagree? WHY?

Question 9

- If you were to give advice to someone looking to start an organization in the ecosystem of recovery, what advice would you give related to successfully acquiring funding?
- What would be one or two specific action items they should consider?

- What about specific things you would warn them against, what are some examples of these?



Optimizing Recovery Funding, Volume 2:

Strategies for State Funding of Recovery Support Services

Rebecca Boss

Neil Campbell

Victor Capoccia

Colette Croze

Jordan Gulley



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1. Executive Summary

In 1998, the Substance Abuse and Mental Health Services Administration (SAMHSA) funded the Recovery Community Support Program (RCSP), which provided foundational support for the organization of the substance use recovery community and played a role in the subsequent development of recovery community organizations (RCOs) and other recovery support services (RSS). Since then, federal, state, and local governments have made significant investments to develop recovery-oriented systems of care (ROSC) and RSS for individuals with substance use disorders (SUDs).

In the fall of 2021, SAMHSA funded the University of Missouri-Kansas City (UMKC) to serve as the national peer-run training and technical assistance (TA) center for addiction recovery and peer support, creating the Peer Recovery Center of Excellence (PR CoE). Among other functions, the PR CoE was tasked with conducting an analysis of how states are spending SAMHSA dollars on recovery support services for people with substance use conditions. The purpose of the analysis is to identify and recommend best practices and strategies for states, municipalities, territories, and tribes in providing financial support for RSS/RCOs. UMKC retained the Technical Assistance Collaborative (TAC) to conduct this analysis.

A mixed method approach — involving desk reviews of public documents, in-depth interviews with ten states, and a Single State Agency survey with 44 responses (42 states and two territories) — was employed by the TAC team to gather, analyze, and report data, and to make recommendations. In addition to highlighting strengths and obstacles related to RSS spending, this first baseline state spending analysis focused on four questions:

1. How much are states spending on RSS/RCO from the following sources only: SAMHSA Substance Abuse Block Grants [SABG], SAMHSA discretionary grants, and state general revenue?
2. What methods are states using to purchase/pay for these services?
3. What types of organizations are states using as vendors?
4. What services are being purchased?

State respondents reporting full financial information (32) spent \$412M from SABG, discretionary grants, and state appropriations, on six categories of RSS in fiscal year 2022, which, when extrapolated to all 50 states (using per capita averages), represents an estimated \$775M nationally.¹ When correlated with data on SUD prevalence,² the reported RSS³ spending ranged from \$9.40 to \$28.60 per capita for persons with SUD, with an average of \$20.78 for all states. It is important to note that spending by source shows that discretionary funding, which *could* be time-limited funds, makes up one-third of the total RSS spend.

RCOs were the organization type identified by most states as providers of RSS, followed by SUD treatment organizations, and then by mental health treatment organizations, community health centers, educational institutions, and a large mix of other organizations. However, in review of total funding allocated, SUD providers received approximately 2.5% more funding for RSS than RCOs did. State support was also manifest in non-financial approaches that include training, workforce development, technical assistance, and organizational capacity-building.

Both community and government stakeholders noted the need for clear reporting requirements and standardization of definitions of RSS in order to adequately track and report what was offered to whom, with what effect. The analysis further identified the need for additional effort to reach and support peer-led community-based organizations, especially among Black, Indigenous, and People of Color (BIPOC); Lesbian, Gay, Bisexual, Transgender, Queer, Asexual (LGBTQIA+); rural; and underserved populations. Finally, the analysis identified the elements that contribute to a successful state RSS program.

The analysis and findings led to recommendations that may be used independently or in coordinated fashion by SAMHSA, other federal agencies, and states. Highlights include:

1. A recommendation that states report to SAMHSA the amount of money from SABG and other discretionary grants spent on RSS, in broad domains that reflect the expenditures.
2. A recommendation that funding agencies develop approaches to expand and diversify the applicant field, in order to better match community needs, address gaps, and build capacity to apply for and manage grants, especially for previously unfunded and underrepresented organizations.
3. A recommendation to increase state opportunities for training, technical assistance, toolkits, and learning collaboratives, specific to funding recovery support services.
4. A recommendation to initiate a consensus process to develop a taxonomy of RSS useful for reporting performance and outcomes.
5. A recommendation to create mechanisms to better coordinate and align goals of interagency funding of RSS at both state and federal levels.
6. A recommendation to initiate a follow-up to [the systematic review of evidence on recovery support services](#) presented to the SAMHSA Recovery Research and Evaluation Technical Expert Panel in 2018.⁴
7. A recommendation that the Office of Recovery in SAMHSA clarify and communicate the vision for RSS, including distinctions as applicable between mental health and SUDs.

This study of state expenditures and of effective practices that support RSS and RCOs was the first of its kind. As such, it is a baseline. Determinants of progress and change require that the essence of the analysis--be how much is spent on what services, by whom, to what effect--, and be repeated in at least biannual intervals. Because of limitations (described below) that prevented the study from capturing the entirety of possible funding, this study should not be used as a definitive source of information on state funding for RSS/RCOs.

2. Introduction

For more than two decades, federal, state, and local governments have made investments to develop recovery-oriented systems of care and related recovery support services (RSS) for individuals with substance use disorders (SUDs). The Substance Abuse and Mental Health Services Administration (SAMHSA) has provided the foundational support necessary for the organization of the recovery community and its subsequent role in the development of recovery community organizations (RCOs), as well as other RSS. In 1998, SAMHSA's Center for Substance Abuse Treatment funded the Recovery Community Support Program, the first of a number of grant initiatives created to support recovery services. Since that time, states and community-based organizations have used these grants to move the field toward adoption of a strong recovery orientation, expanding service options to those in need and emphasizing the value of engaging individuals with lived experience. As the RSS field continues to evolve, it is essential that rigorous research be conducted to identify evidence-based practices in both service delivery and system implementation.⁵

In September 2021, SAMHSA awarded a grant of regional and national significance to the University of Missouri-Kansas City (UMKC) for a national “peer-run training and technical assistance center for addiction recovery peer support.” This entity, the Peer Recovery Center of Excellence (PR CoE), was tasked to work with the peer workforce, RCOs, and other organizations integrating peer recovery support services for SUD recovery into their offerings. SAMHSA provided supplemental funding to the PR CoE for a special project to identify and recommend best practices and strategies to optimize funding for high-quality and effective recovery support services. This two-part project involved an assessment of opportunities and barriers experienced by providers of RSS in accessing funding. The second part of this work required the PR CoE to engage qualified consultants to conduct a state-by-state analysis of state budget spending of SAMHSA dollars on RSS. These two analyses were coordinated in their design to provide a national perspective on both the state funding currently available, and the local RSS this funding purchased. An effort such as this, designed to advance the understanding of RSS of development, support, and standard-setting for these services — both locally and at the state level — is consistent with the 2022 National Drug Control Strategy as well as with current research.^{6, 7, 8}

The PR CoE approved a proposal from the [Technical Assistance Collaborative \(TAC\)](#), a nonprofit consulting practice deeply experienced in state behavioral health financing and in regulatory and quality practices, to conduct the state financing component of the analysis. The TAC team applied its experience in recovery, state administration, advocacy, financial analysis, local SUD service delivery, national policy, and survey research in the analysis process.

The overall purpose of this project was to identify and recommend best practices and strategies for states, municipalities, territories, and tribes to provide financial support for a wide range of high-quality and effective RSS aimed at individuals and families with SUDs. Understanding these practices and strategies will allow SAMHSA, the Centers for Medicare and Medicaid Services (CMS), states, and local entities to develop strategies to ensure that funds are used efficiently. It will also enable states to improve their RSS purchasing and contracting practices.

The goals of the state funding analysis were to gather information on amounts of recovery-specific funding provided, determine the percentage of Substance Abuse Block Grant (SABG)

funding utilized for recovery support services, and perform a quantitative and qualitative review of exemplary funding and contracting processes. The body of knowledge about the role, nature, and effectiveness of RSS is in an early stage of development; this effort adds to the understanding of one dimension, *states' roles*, and addresses the following questions:

- How much are states spending on RSS from SAMHSA funds and, where possible, from other sources?
- What types of RSS are states purchasing?
- From what types of organizations are states purchasing RSS?
- What purchasing strategies are states using to fund RSS?
- What barriers have states encountered to funding RSS?

The data gathered can inform SAMHSA's future guidance, technical support, and use of federal funds for recovery support services. The information can also provide benchmarks for states to use in developing their future strategies and expenditures for recovery support functions.

3. Methodology

This study is exploratory, as there are no previous studies focused on state expenditures for RSS and RCOs. The study employed mixed quantitative and qualitative methods that describe and summarize the current status of state spending for RSS and RCOs. Data were gathered through desk review of public documents; structured interviews; and a survey of all SAMHSA SABG recipients. The data-gathering process included a targeted review of published and gray literature, as well as public state websites.

Quantitative data were reported with simple descriptive statistics, as inferential or associational methods are not appropriate for these data at this time. Qualitative data were clustered into themes and reviewed by at least two peer reviewers. For a more in-depth review of methodology and approaches used, [see Appendix B](#).

3.1 Approach

A brief description follows of the general approaches used to execute the methods described above. These approaches are described in more detail in [Appendix B](#).

3.1.1. Context-Setting Interviews

The first step in the project involved connecting with 10 carefully selected organizations that could provide a context for the project. Conversations with these stakeholders yielded valuable feedback on the project's approach, including identification of 10 exemplary states for in-depth interviews, and member recommendations for the Expert Advisory Committee.

3.1.2. Expert Advisory Committee

A small number of individuals were invited to serve on the State Budget Analysis Advisory Committee, who became part of the larger SME panel for this project ([See Volume 1](#) for composition of the SME panel). This group served to validate questions and suggest approaches to gathering the desired data from states and funding sources ([See Appendix A](#) for a list of Expert Advisory Committee members). This group guided and informed our methodology, instruments, processes, and analyses, and helped ensure that components of the final report were inclusive and accurate reflections of the needs of both states and the recovery service community.

3.1.3. Information Collection

There were four primary sources for our information on each state's RSS landscape:

- **Context-setting interviews** for information on financing, research, collaborative learning, statewide RCO networks, and challenges that accompany funding for RSS.
- **Desk audits** of existing applications and reports collected by SAMHSA regarding state investment in RSS from the SABG (online WebBGAS platform) and review of the National Association of State Alcohol and Drug Abuse Directors' State Targeted Response and State Opioid Response (STR/SOR) Profiles (2017–2019).
- **Structured and recorded interviews** with 10 states identified as "exemplary" by stakeholders from the SME Panel, in the context-gathering interviews, and by the State

Budget Analysis Advisory Committee (See [Appendix C](#) for the Interview Guide and a list of interviewees).

- **The project's Single State Agency (SSA) Survey** requesting key data elements covering RSS funding, state contracting and payment practices, challenges encountered in funding RSS, and successful strategies for addressing those challenges. (See [Appendix D](#) for the survey and [Appendix E](#) for a glossary of terms.) The survey gave states the opportunity to provide feedback in a narrative section. States' comments and recommendations have been woven throughout this report. [Appendix F](#) provides a summary of these responses.

4. Limitations

The primary limitations for this study are as follows: The financial analysis of RSS spending relied solely on a self-report survey. The team reviewed the WebBGAS system, but specific budgetary information regarding RSS spending was not reported in state SABG applications or reports. Additionally, the team made a request to SAMHSA for SOR applications and reports, but the information had not been received by TAC at the time of the analysis. Due to limited previous research and studies on this topic, there was limited information regarding RSS spending and no opportunity to cross-reference results.

The structure and utilization of the RSS survey were limited by specific factors:

- The mechanism of survey created the potential for variation in reported funding sources. For example, although the survey requested information on SUD RSS spending, some states reported RSS purchased through Mental Health Block Grant (MHBG) dollars. It was not always apparent whether RSS purchased through MHBG funds were used to provide SUD RSS or only mental health support. Additionally, in several states, it was reportedly difficult to identify SUD-specific RSS due to the braiding of funding, the integration of substance use services and mental health services, or joint credentialing for peer recovery support services. For this reason, the examination of SAMSHA funds focused on SABG and discretionary spending but MHBG-reported funds were included in total RSS spending reports.
- A common theme of the context interviews was inconsistency in definition and categorization of RSS across states. In order to mitigate this concern relative to RSS definitions, the team synthesized services into six broad categories (recovery community centers, recovery housing, peer recovery coaching, peer workforce development, recovery supports, and other) and provided working definitions for the terms in the survey. An unintended consequence was a high rate of utilization of the “other” classification when states were not able to discern appropriate categorization.
- The limited scope of questions and a multiple-choice selection process allowed for a concise approach to collecting information from states, but may have resulted in simplistic data representing a complex and nuanced process. For example, 27 states reported a process for community engagement, but this data point does not get to differences in level, intensity, or representation of the community engagement practice. This limitation reflects the challenge of balancing survey brevity against the longer and more comprehensive probing necessary to understand the complex landscape of budgeting, procurement, support, and engagement functions for RSS.

The team requested RSS spending from the last completed fiscal year (FY), FY22, which had significantly higher SAMHSA SABG allocations due to supplemental awards through COVID-19 funding and the American Rescue Plan Act (ARPA). This impacted the calculation of the percentage of SABG allocated to funding RSS. Furthermore, there was a disparate impact of RSS spending across states due to the fact that the ARPA provisions can be allocated until 2025, so the utilization rate of supplemental SABG funds varied across states. To mitigate this anomaly in the total SABG allocation, the team projected a percentage of SABG to be spent on RSS in FY23. This predication utilized the reported RSS spend from FY22 relative to the SABG state allocations for FY23, when SABG allotments will have returned to baseline (see **Table 12**).

Though the study attempted to capture state general revenue funds, due to the confines of the study, the analysis does not include any Medicaid spending on RSS. This information would have been challenging to gather given differences in state infrastructure and the above-noted difficulty discerning specific RSS spending. For this reason, the state total spend on RSS does not provide a comprehensive view.

Due to the above-mentioned limitations of the study analysis in capturing the entire potential funding sources for RSS, this study should not be used to describe the current level of state expenditures on RSS.

5. Findings

The findings reported below are drawn from all three data sources: interviews, desk review, and survey. The narrative accompanying our quantitative and qualitative data is also drawn from these three sources. The narrative includes illustrative examples from states in order to highlight the data. State-specific content derived from interviews was verified with states prior to inclusion in the final report. All other state-reported references were obtained from public documents or surveys completed by states.

5.1 Finance Findings

Both the SSA survey and the in-depth interview guide addressed three dimensions of finance of interest to SAMHSA:

- How much are states spending from different sources of revenue?
- What types of services and providers are these funds supporting?
- What methods are states using to purchase and pay for these services?

In addition, the survey asked whether there were other state agencies or funding sources supporting RSS/RCOs, and how SSAs were attempting to coordinate contracts and expectations across funders.

5.1.1. Spending and Services

The survey, distributed to SABG-funded states, territories, municipalities, and tribes, asked about SAMHSA-funded RSS funding from SABG, discretionary grants, and other for six major service types⁹; the survey also asked about the types of organizations that were funded. The survey asked for this same information for state general fund spending. There was an 84% response rate among the states. Although 42 states responded to the survey, only 32 reported budgetary information, for a variety of reasons. These 32 states reported spending \$412M from SABG, discretionary grants, and state appropriations on recovery support services in state fiscal year 2022 directed to the six major service types.¹⁰ Although there are no benchmarks to guide the allocation of funds for RSS/RCOs given the nascent nature of these services and organizations, the fact that the 32 survey respondents spent over \$400 million in state and federal funds is noteworthy. Funding is represented across five regions used to geographically categorize the states; the number of respondents by region is identified in **Table 1** below.

Table 1. Respondents per Region*

REGION*	Number of States & Territories	Number of States & Territories Responding
Northeast	12	12
Southeast	12	9
Midwest	12	8
Southwest	4	4
West	11	9
State Total	51	42
Territories	5	2
Totals:	56	44

* **Northeast:** Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut, New York, Washington DC, Delaware, Maryland, New Jersey, and Pennsylvania. **Southeast:** Florida, Mississippi, Alabama, Georgia, South Carolina, North Carolina, Virginia, Arkansas, Kentucky, Louisiana, Tennessee, and West Virginia. **Midwest:** Iowa, Illinois, Indiana, Michigan, Missouri, Nebraska, Ohio, Wisconsin, North Dakota, South Dakota, Kansas, and Minnesota. **Southwest:** Arizona, New Mexico, Oklahoma, and Texas. **West:** California, Oregon, Washington, Nevada, Alaska, Hawaii, Colorado, Idaho, Montana, Utah, and Wyoming.

In designing the SSA survey, TAC tried to balance the significant need for information with the understanding that for many if not most states, this could be the first time they had been asked to provide detailed information on RSS and RCO funding. It was beyond the scope of this project to analyze state service definitions or other components of each state’s administration of RSS/RCO funds in order to understand the classification system they used for these services and organizations. Knowing this, TAC developed “Working Definitions of Terms” ([Appendix E](#)) to help states categorize their RSS funding. Even with this set of working definitions, there was considerable variability in some of the service classifications, especially Recovery Support.

Acknowledging the limitations of the service classification system, state spending was distributed across the service categories as shown in **Tables 2** and **3**:

Table 2. Regional Spending by Service Type

Region	Recovery Community Centers	Recovery Housing	Peer Recovery	Workforce Development	Recovery Support	Other	Total
Northeast	\$25,568,054	\$13,097,395	\$32,405,409	\$7,535,256	\$43,935,858	\$10,754,714	\$133,296,686
Southeast	\$11,125,671	\$27,624,828	\$17,812,449	\$1,508,408	\$31,693,774	\$6,865,276	\$96,630,406
Midwest	\$14,371,683	\$10,248,666	\$16,861,341	\$5,827,101	\$30,795,817	\$2,773,391	\$80,877,999
Southwest	\$3,701,346	\$6,390,593	\$4,000,000	\$650,000	\$19,251,332	\$2,987,619	\$36,980,890
West	\$7,912,700	\$9,054,826	\$6,621,309	\$1,841,000	\$30,421,235	\$8,200,400	\$64,051,470
State Total	\$62,679,454	\$66,416,308	\$77,700,508	17,361,765	\$156,098,016	\$31,581,400	\$411,837,451
Territories	\$3,204,416	\$2,339,459	\$211,080	\$47,143	\$150,000	\$0	\$5,952,098
Total	\$65,883,870	\$68,755,767	\$77,911,588	\$17,408,908	\$156,248,016	\$31,581,400	\$417,789,549

Table 3. Percentage of Recovery Support Services Funding by Type of Service

Service Type	RSS Spend
Recovery Community Center	15%
Recovery House	16%
Peer Specialists	19%
Workforce	4%
Recovery Support	38%
Other	8%
Total	100%

TAC also looked at the distribution of RSS/RCO spending across funding sources. For the 31 states that reported RSS spending by source, the sources are equally represented.

Table 4. RSS/RCO Spending by Source (\$ in millions)*

Source	SABG	Discretionary	Total Federal	State	Total ¹
Dollars	\$126.7 M	\$125 M	\$251.7 M	\$122.6 M	\$373.4 M
% Total RSS Spend	34%	33%	67%	33%	100%

* Due to one state reporting SABG and State funds together, that state has been removed from this chart, which is why the total reflects \$373.4 million rather than \$411.8 million.

Growth in RSS/RCO funding has been rapid. **Massachusetts**, for example, funded 10 recovery support centers in 2013, 16 were added in 2019, and one more in 2022, to total 27, and there are plans to add another 10 to 15 in 2023. **New Jersey** has Certified Peer Recovery Centers in every county. **Indiana** funded its statewide RCO in 2019 and now has 28 recovery community centers and cafés, with a waiting list of organizations that would like to pursue funding. **Illinois** currently funds 20 agencies that cover 30 counties to implement the Recovery Oriented Systems of Care-IL Statewide Networks (ROSC-ISN) to establish geographically distributed ROSC councils assisting communities with building local recovery-oriented systems of care. All ROSC councils, as part of their three-year strategic plan, are to move towards creating an RCO in their community. States’ investment in RSS/RCOs has grown substantially, and the RSS/RCO footprint has expanded across various organizational types, settings, and special populations.

With the caveats noted about classification of services, states are predominantly funding a mix of place-based services (recovery community centers), recovery housing, and peer support. The survey inquired about “services” that states funded but the provided definition and terminology may have led to differences in interpretation, resulting in states reporting lower investments in workforce than in other classifications. As the survey did not explicitly ask about state expenditures to support the peer workforce and workforce investments, such as training,

recruitment, and retention, efforts may have been underreported. Additionally, workforce investments are typically subject to administrative caps. Future surveys could focus more closely on investments for the peer workforce.

In addition to the SSA, other parts of state government support RSS/RCOs. With growing attention to the prevalence of SUDs (and opioid use disorder in particular) in the justice-involved population, it is not surprising that criminal justice was most frequently mentioned; health and child welfare agencies are moderately active, with labor and housing agencies involved to a lesser degree.

Table 5. State RSS/RCO Funding through Non-SSA Agencies

State Agency Supporting RSS/RCO	Number of States
Justice	22
Child Welfare	13
Health	11
Housing	9
Labor	9
Medicaid	34

Table 6. Other Funding Sources for RSS/RCO

RSS/RCO Funding Source	Number of States
Opioid settlement	12
U.S. Centers for Disease Control & Prevention (CDC)	6
Administration for Children & Families	5
U.S. Health Resources & Services Administration (HRSA)	5
Department of Justice	5

Thirty-four states indicated that Medicaid provided coverage for recovery support services; however, in the six of these states without Medicaid expansion, individuals with SUDs may not have access to this benefit. **Kentucky** and **Indiana** are particularly active in cross-agency funding. In Kentucky, the Department of Corrections, the Administrative Office of the Courts, the Department for Community-Based Services, the Department of Public Health, and the Office of Drug Control Policy all fund recovery support services. In Indiana, a variety of state agencies fund these services, including the Department of Corrections through its \$20M *Recovery Works* wraparound voucher program.

As a companion question to the identification of multiple state and federal funding sources, respondents were asked to identify any actions the SSA was taking to ensure alignment across the various sources. Thirty-nine states responded to this question, of which 23 were using a task force, workgroup, or other established coordinating body; 11 coordinated efforts under a single umbrella state agency; and eight used purchasing mechanisms to align the contracting process. Of the three identified approaches, 8% used one, 21% used two, and 50% used all three; 18% of the states were not active in aligning funding sources. One alignment effort of note is in **Kentucky**, which has a statewide implementation team that oversees funding and contracting for RSS/RCO through a cross-agency group that include the agencies mentioned previously. With RSS/RCO funding increasingly occurring outside of the SSA, it is important that mechanisms be established to coordinate between agencies in order to synchronize programmatic objectives, balance service and population coverage, avoid duplication, and reduce administrative burden on providers.

5.1.2. Providers, Services, Settings, and Populations

States fund a variety of organizational types to provide SUD RSS, with RCOs being the most

prominent and SUD treatment organizations the second most likely type. As with the caveat previously described about the percentage of funds being spent on recovery supports, the fact that the third most likely category of funded organizations is “other” points to the need for further review with states to possibly create more useful organizational categories. As shown in **Tables 7 and 8**, other categories included statewide RCOs, mental health treatment providers, primary care providers, hospital emergency departments, and community health centers. Funding amounts of RCOs and SUD treatment providers are demonstrated in **Table 8**.

Table 7. Organizations Providing Recovery Support Services in 39 Reporting States*

Types of Organization Providing RSS	States
Statewide RCOs	10
RCOs	31
SUD treatment providers	26
Mental health treatment providers	10
Primary care providers	4
Hospital emergency departments	6
Community health centers	7
Other	28

* In answering the survey question about use of successful strategies, 16 states said they provided support to new providers through statewide RCOs and two states interviewed said they funded statewide RCOs. Combining the three sets of responses, 20 states have statewide RCOs.

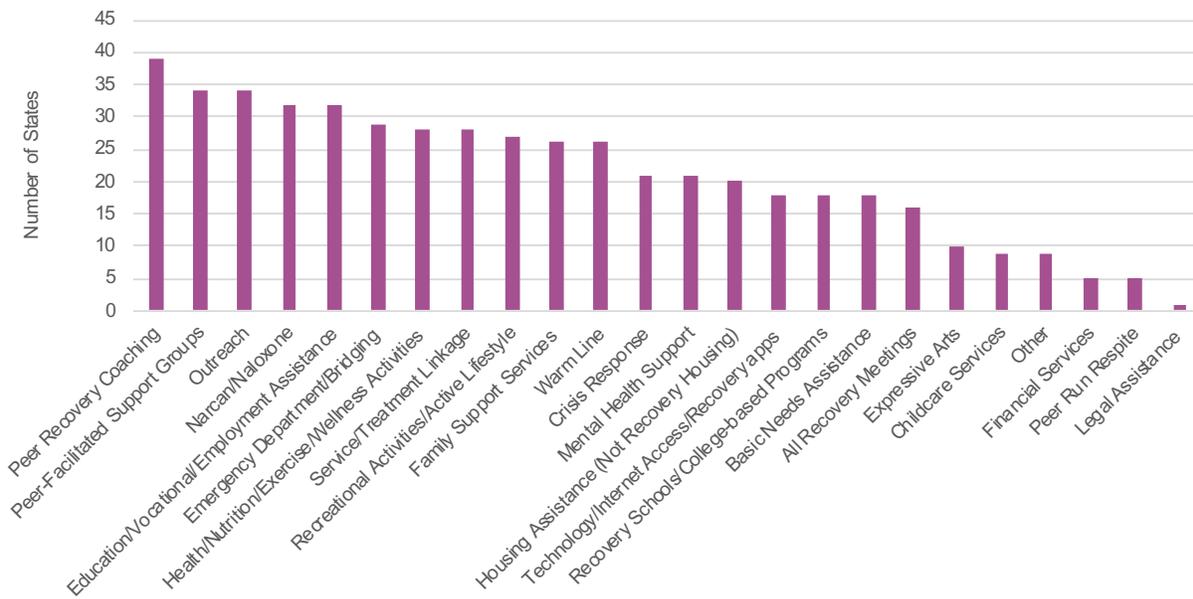
** Because of inconsistencies across state spending reporting and the use of the “other” category for agency type, we pulled the specific dollar spend for only the two most funded organization types (RCOs and SUD providers).

Table 8. RSS Spending by Organization**

RSS Spending	SABG	Discretionary	State	Total Funds
Total state spend	\$126,678,579	\$125,000,734	\$122,649,883	374,329,196
State spend on RCOs	\$35,672,366	\$32,727,656	\$28,889,100	\$97,289,122
Percentage of total spent on RCOs	28.1%	26.2%	23.6%	26%
State spend on SUD treatment providers	\$38,629,361	\$35,992,998	\$33,629,321	\$108,251,680
% of total spent on SUD treatment providers	30.5%	28.8%	27.4%	28.9%

Specific spending information was only provided for the six major categories of RSS previously listed. In addition, states were asked to specify which services or activities they supported under the RSS category. As **Figure 1** indicates, states are supporting a wide array of specific services in the 24 categories the survey listed.

Figure 1. Recovery Support Services Purchased by States



Additionally, settings where RSS are provided were categorically consolidated. RSS located in an SUD treatment setting were most prominent, followed by recovery community centers, justice, health care, and educational environments.

Table 9. Settings where Recovery Support Services are Delivered

RSS Delivery Setting	States
SUD treatment provider	39
RCC/café/clubhouse	34
Justice	33
Health	32
Educational	15

In the survey, states were asked to indicate what “specialized RSS” they fund for 13 population groups (See [Appendix G](#)). States were most likely to target RSS to justice-involved populations, pregnant or post-partum individuals, and people who are homeless; they were least likely to tailor RSS to individuals whose preferred language is Spanish, those with disabilities, people who identify as LGBTQIA+, or older adults. Most regions included some states that targeted all 13 population groups. Through review of SABG applications and interviews with the targeted states, several strong initiatives were identified for targeting specialized RSS and RCOs:

- Prioritizing Black, Indigenous and People of Color (BIPOC) in RCO funding allocations
 - Issuing selective RFPs for specific recovery communities, e.g., BIPOC, Latinx, etc.
 - Investing in historically underfunded BIPOC-led organizations through the provision of technical assistance, contract development, and community advocacy and coordination.
- Through such efforts, one state now has five population-specific RCOs, with one organization

focusing on each of the following groups: Black/African-American communities; Latinx and Spanish-speaking communities; Native communities; African-American women transitioning from jail; young adults; and LGBTQIA+ communities.

- Partnering with a BIPOC community organization to raise awareness and reduce stigma associated with substance use within BIPOC communities. One community partner awarded grants to organizations that were invested in and reflective of affected communities of color.

5.1.3. Procurement and Payment

An important consideration in a state's support of RSS/RCOs is how it makes funds available to organizations and how they pay contractors once an award is made. States have procurement laws, systems, and requirements that vary widely and present different degrees of challenge and complexity for applicants to negotiate. States seek to strategically select purchasing strategies that are accountable, fair, transparent, and "applicant friendly," especially with a type of service that's relatively new and is often provided by organizations with little or no experience applying for public funding. In addition, some states have chosen to offer assistance to community-based RSS providers in grant application processes, or proposal writing. **Colorado**, for example, funded a grant writing consortium so that every RSS RFP that goes out for bid has a link to the consortium's website for assistance with applications.

Of the 42 respondents, 21 used sole source contracting, 25 used selective contracting, and 31 used competitive procurement to solicit applications for funding. Overall, 57% of states used more than one method of procuring RSS/RCOs and 24% of states used all three methods.

Roughly equal numbers of states reported using three of the four identified payment methods, with 26 funding through grants; 25 using fee-for-service (FFS) reimbursement; and 27 providing cost-based reimbursement. Only seven states are using performance contracting for RSS/RCOs. As with the purchasing methods, most states used multiple methods to pay for RSS and RCOs, with 71% using more than one payment method; 29% using three approaches; and 10% using all four. For newly funded organizations, grants are the easiest to manage and provide greater predictability, with consistent funds flowing in 1/12 monthly payments. Both cost reimbursement and FFS present greater challenges, as they require the provider to make expenditures before they have received reimbursement, with varying lag times in payment.

The SSA survey asked about particular challenges states have faced in contracting with RSS providers or RCOs: 23 states cited workforce challenges; 16 identified lack of funds for infrastructure development; 12 reported that many providers were not familiar with the state's contracting process; the same number cited the inability of RSS providers to meet state requirements; and 11 selected "lack of state capacity" as an obstacle in funding RSS/RCOs. In response to these and other challenges, successful strategies were identified as: providing technical assistance, selected by 31 states; being clear about the state role, selected by 18 states; providing support from a statewide RCO, selected by 16 states; and modifying purchasing or reporting requirements, selected by 14 states.

From state interviews, survey comments, and state SABG applications, TAC identified numerous strategies being used to reduce barriers in applying for and receiving funding. These included:

- Using an existing exemption from the formal state procurement process
- Creating a more accessible application system
- Developing a tailored and simpler application process

- Using a Notice of Funding Opportunity, which is much less cumbersome than issuing an RFP
- Issuing Requests for Information (RFIs) in advance of RFPs in order to allow RSS providers and RCOs to review and comment on key elements of the application process and scope of work

Several states use a variety of procurement methods but distribute the majority of funds for RSS/RCOs through selective contracting; others have developed RSS and RCOs through pilot projects and non-competitive funding. One state tailors its purchasing strategy specifically for RSS by level of care and type of service being procured. Some states have delegated procurement to non-state entities, in one case an existing system of managed service organizations (MSOs) and, in another, the statewide RCO, to allow for a streamlined process. Several states initially allowed flexibility in procurement process and payment for RSS/RCOs, progressively adding standards beyond core oversight requirements. **Colorado**, for example, developed contracts with careful attention to the language from the state statute regarding RCOs so that funding did not flow only to established treatment providers, but also to emerging community organizations. Several states specifically target funding and RFPs to RCOs in order to bring new, peer-governed organizations into their provider networks. In **South Carolina**, an RSS provider may be awarded funds as a sole source provider based on the services they're offering, the population served, and the proposed service area.

States also created flexibilities in payment mechanisms; finding ways to prepay for startup costs like training, information technology support, etc., allowing payment for any activities the RCOs were involved in, from peer support to fitness centers; and front-loading state payments to moderate cash flow. Many states use more than one payment method, often a mix of monthly fixed payments, advanced payments, or some combination, e.g., monthly fixed payments for operations with add-on payments for specific deliverables. To facilitate payment for RSS, **Missouri** has made a concerted effort to reduce paperwork requirements, allowing providers to focus on direct service provision.

5.1.4. Regional Comparisons and Projections

In an attempt to create some baseline financial information and to compare spending across the five regions into which the states were organized, TAC looked at the range in per capita RSS spending among all states, and per capita RSS spending across the geographic areas, in two ways. For the per capita comparison, we first report per capita spending based on the entire state population and, second, by the “prevalence per capita” using state-specific SUD prevalence estimates for individuals 12 and older, as found in the National Survey on Drug Use and Health (NSDUH) 2020 report (the most recent publication year).¹¹ Incorporating an analysis of prevalence rates takes into account state/regional differences in need that could impact RSS investment. Data for both 2022 and 2023 are presented for RSS spending as a percentage of the SABG since 2022 allocations were significantly higher than “baseline years” because of supplemental awards related to COVID-19 and ARPA. Use of FY23 data *may* represent a more accurate picture of the percentage of SABG funds supporting RSS in a typical year.

TAC is presenting this information only for foundational purposes since there are no established benchmarks for the “correct” numbers in this area. As stated in the methodology section, this report presents descriptive statistics only, with no inferential analysis, given the exploratory nature of the data collection. With more sophisticated research, the differences presented here should be further analyzed to identify factors that drive the variation.

Tables 10a and **10b** compare regional per capita RSS spending for the state’s population as a whole (all ages) with per capita RSS spending based on the NSDUH prevalence estimates for individuals 12 and older who meet NSDUH criteria for addiction. Per capita spending shows

state spending by a single constant variable, e.g. population, which provides a baseline for comparison. In recognition that SUD prevalence rates vary among states, a secondary analysis using NSDUH data provides an opportunity to view state spending that incorporates identified need. Both are included to provide a more comprehensive overview of state spending. Both show significant ranges in per capita spending, either overall or based on prevalence.

Table 10a. Range in State RSS Per Capita Spending for Total Population in 32 Responding States

Per Capita RSS Spending	States
Less than \$2	17
\$2 to \$5	11
Over \$5	4

* Individuals age 12 and older

Table 10b. Range in State RSS Per Capita Spending for Persons with SUD in 32 Responding States*

Per Capita RSS Spending	States
Less than \$10	7
\$11 to \$20.99	6
\$21 to \$30	9
Over \$30	10

As shown in **Tables 11a** and **11b** below, similar ranges in per capita spending are found in different regions. For the whole state population per capita, the highest region spends \$3.28 while the lowest region spends \$1.10. Using the prevalence-based data, per capita spending ranges from \$9.40 to \$28.50. Again, these data are presented as foundational only, since there are no benchmarks for determining the “right” per capita spending for RSS.

Table 11a. State per capita RSS Spending for total population by Region**

Region	Per Capita RSS Spending, Total Population
Northeast	\$3.09
Southeast	\$2.31
Midwest	\$1.38
Southwest	\$1.10
West	\$3.28
All states	\$2.09
Territories	\$1.79
Total	\$2.10

Table 11b. Range in Per Capita RSS Spending for Persons with SUD by Region***

Region	Per Capita RSS Spending for Persons with SUD
Northeast	\$27.56
Southeast	\$28.60
Midwest	\$14.61
Southwest	\$9.40
West	\$26.51
All states	\$20.78

** Individuals age 12 and older; states reflected in this chart are those that provided budgetary information.

*** Territories were not included in this calculation because there are no National Survey on Drug Use and Health (NSDUH) estimates available.

As shown in **Tables 12a** and **12c** below, RSS spending as a percentage of the SABG shows similarly wide ranges for FY22 and FY23. For FY22, 42% of states spent up to 4% on RSS; 35% of states spent 4% to 8%; 17% of states spent 9% to 10%, and 6% of states spent over 10%. It should be noted that there is a significant difference between Federal Fiscal Year (FFY) 22 and FFY 23. This reflects the anomaly of increased American Rescue Plan Act and COVID funding, which significantly increased SABG allocations in FFY 22. For instance, **West Virginia** received approximately 3.5 times more funding through the SABG in FFY 22 than what is allocated for FFY 23. Using what may be typical baseline information projected for FY23, only 6% of states will spend under 10%; 29% of states will spend from 10% to 15%; 26% of states will spend 16% to 25%; and 26% of states will spend more than 25% of SABG funds on RSS.

Table 12a. RSS Spending as a Percentage of Block Grant for FY22 in 32 Responding States*

% of Block Grant Used for RSS, FY22	Up to 4%	4.0 – 7.9%	8.0 – 10.0%	Over 10%
Number of States	13	11	5	2

* Excludes one state which rolled state funds in with its SABG funds when reporting

Table 12b. Percentage of Block Grant Spent in FY22 on RCOs*

% of Block Grant	Up to 1%	1.1 – 2.9%	3.0 – 4.9%	5.0 – 6.9%	Over 7%	All States
Number of States	14	8	3	2	1	28**

* RCO is defined here as “A single organization, governed by people in recovery, whose function is to provide support, such as infrastructure development, training, technical assistance or coordination to local organizations delivering recovery support services. A statewide RCO promotes recovery-focused policies, mobilizes people in recovery and allies, and supports the development and implementation of recovery services and supports in communities of color as well as immigrant, indigent and refugee communities through intentional outreach and action.”

** Excludes four states who either did not break down funding by organization type or combined SABG funds with other funding when reporting

Table 12c. RSS Spending as a Percentage of Block Grant for FY23, Using RSS Spend for FY22, in 32 Responding States (assuming SABG Spend stays the same)*

% of Block Grant Used for RSS, FY23	Under 10%	10.0 – 14.9%	15.0 – 25.0%	Over 25%
Number of States	6	9	8	8

* Excludes one state which rolled state funds in with its SABG funds when reporting

Table 12d. Estimated Percentage of Block Grant Spent in FY23 on RCOs

% of Block Grant	Up to 3%	3.1 – 6.0%	6.1 – 9.0%	9.1 – 12.0%	Over 12%	All States
Number of States	13	5	3	2	5	28*

* Excludes four states who either did not break down funding by organization type or combined SABG funds with other funding when reporting

Table 12c assumes that RSS spending would remain constant as states would be unlikely to tie such time-limited funding to services that would then need to be discontinued. This chart is included

as it may reflect a more typical depiction of RSS spending as a percentage of the block grant.

Table 12b and **12d** reflects the FFY SABG spend allocated to RCOs. It is important to note that the funding here is specific to the definition of the organization type as specified in [Appendix E](#). As defined for this purpose, RCOs are governed by people in recovery. There are discrepancies in the field that the definition should be “primarily” governed by people in recovery. The latter definition would likely create significant change in these percentage numbers as states may have been more likely to include RCCs or some of the provider types listed as “other.”

In order to show the relationship between state spending and state population, TAC developed a scattergram of spending versus population and SUD prevalence. **Figures 2** and **3** reflect the general trend that as the state population increases, so does spending. The trend line indicates a positive correlation between the two variables; however, it is not an indicator of any causal relationship.

Figure 2. State Spend Per Capita on Recovery Support Services for Total Population**



** One outlier state was removed as it was skewing the data sample.

Figure 3. State Spend on RSS for Persons with SUD*



* Includes individuals 12 or older diagnosed with SUD; One outlier state was removed as it was skewing the data sample.

Finally, TAC used each of the regional population per capita amounts to project spending for states that did not respond to the survey, and then to calculate projected national spending for all states. Using the regional average spend per capita, the rate was applied to the missing states' census data. **Table 13** indicates that total national spending for RSS would be \$775M, if all states had responded to the survey which showed that 32 states spent \$412M in FY22.

Table 13. Projected Total Spend Using Per Capita by Region

Region	Estimated Total RSS Spend Based on Total Population
Northeast	\$200,757,427
Southeast	\$205,852,764
Midwest	\$88,754,197
Southwest	\$47,312,302
West	\$232,718,690
TOTAL	\$775,395,381

5.2 Engagement

An important component of a state's service planning process is engaging people with lived experience (PWLE) in an advisory capacity in multiple ways. This project attempted to determine whether PWLE were specifically targeted for significant membership, whether any RSS-specific processes were established, and whether RSS/RCOs were specifically addressed. Both the survey and the in-depth interview guide asked states about formal mechanisms for involving individuals in recovery in the decision-making process for funding RSS.

Twenty-seven states responded affirmatively to the survey question on community engagement. Through survey comments and in-depth interviews, information was gathered on the specific activities used by states to engage the recovery community. These activities fell into four categories:

5.2.1. State staff who directly connect with the recovery community

In **Maryland**, for example, through the Consumer Affairs Unit, individuals with lived experience are both employed and engaged on a regular basis as policy and programs are developed. **South Carolina** employs Recovery Service Coordinators, people in recovery who facilitate quarterly meetings for all RSS providers to help promote alignment with the state's mission and its vision of recovery services. Several states have recovery services staff who are involved in policy and funding decisions. In **Oregon**, staff in the Office of Recovery and Resilience (ORR) all have lived experience and are responsible for community engagement to ensure that the voice of recovery is guiding ORR's work. Overall, the surveys and interviews identified more than a dozen states with dedicated staff or organizational units responsible for outreach to the recovery community.

5.2.2. Specific advisory councils and workgroups

A significant number of states have specific peer advisory groups or targeted councils that involve individuals in recovery. **Oklahoma** has a peer advisory council, and **Louisiana's** Heroin and Opioid Prevention and Education (HOPE) Council has workgroups and focus groups with individuals in recovery. **Indiana** has created a specific recovery service infrastructure connected to the pre-existing state planning council. As a subgroup of its state planning council, Indiana established the Indiana Recovery Council, composed of 16 people in mental health and substance use recovery who identify gaps in recovery support services; the state's Recovery Support Workgroup, at least 51 percent of whose members are individuals with lived experience, recommends support service solutions to the Planning Council. **Colorado's** new Behavioral Health Administration will have a steering committee that intentionally includes people and families with lived experience.

5.2.3. Focus groups and surveys to gauge community need

Several states have communication processes for engagement such as learning collaboratives, online meetings, focus groups, or periodic use of surveys to gather input from the recovery community. **Massachusetts**, for example, has recovery support learning communities, peer communities, and monthly online meetings with the peer recovery support centers; the state also conducts biannual surveys of 400 peer recovery support specialists and their supervisors. **Connecticut** uses a formal consultation process with the recovery community, and **Alaska** has a consumer survey system. **Indiana's** Office of Consumer and Family Affairs (known as Recovery Support Services Division as of 2022) conducts a statewide recovery survey to the State Mental Health Planning Advisory Council and collects approximately 700 responses annually. An umbrella agency, the Family and Social Services Administration, conducts focus groups, and the Recovery Support Services Director coordinates input from the recovery community.

5.2.4. Consultation with the statewide RCO

A growing number of states are involving their statewide RCO in planning and funding processes since these organizations are not only peer-led but also have strong connections to significant numbers of RCOs and recovery community centers. For example, **Georgia** and **Missouri** partner on their statewide RCOs to help them understand which recovery supports are needed in communities.

Promising Practice

Pennsylvania launched the *Recovery Rising* initiative to engage stakeholders in strategically planning for a recovery framework and to gain a broader view of the recovery landscape since the Commonwealth previously had no connections with the recovery community. Through Recovery Rising, Pennsylvania convened the recovery community, opened the dialogue, and collectively identified priorities. From this work, six specific projects are underway: a feasibility analysis of stakeholder recommendations; a facilitated dialogue on peer workforce issues; a web-based directory of RCOs; a Racial Equity Transformation Team to advise the Commonwealth; regional RCOs to support local needs; and recovery-focused positions within the Department of Drug and Alcohol Programs.

5.3 State Support for RSS and RCOs

5.3.1. State Support Defined

There are many ways, in addition to financial and legal/regulatory guidance functions, that state agencies can support the initiation, development, and sustainability of RSS and RCOs. State agencies commonly make both procedural and technical information available through multiple channels including technical assistance, learning activities (webinars, collaboratives, and seminars), and resources published in print and web-based electronic formats. The amount of state agency support is an indicator of the priority or importance assigned to a topic or function, relative to all other topics or functions of the agency. While not readily quantified, the absence or minimal presence of state support for a program most often manifests in diminished program impact, while the inverse — strong and visible state support for a program — manifests in presumed positive program impact.

5.3.2. State Supports: What are States Doing?

Both the survey and in-depth interviews identified a wide range of state agency support functions provided to assure universal access to RSS and RCO and especially for underserved residents. **Table 14** identifies the number of responding states that provide one or more of these functions. Eleven states provided all options of support; 22 states provided at least four; 31 states provided at least three; and 35 states provided at least two supports. These functions were delivered by state employees, and/or through 20 statewide organizations tasked specifically to expand the number, reach, effectiveness, and sustainability of peer-led organizations available to deliver RSS.

Table 14. State Strategies to Support RSS/RCOs

Region	Training	TA	Capacity Building	Toolkits	Workforce Develop.	Other	Doesn't Apply	States that Responded
Northeast	9	10	8	2	5	-	2	12
Southeast	8	8	6	3	5	-	-	8
Midwest	8	8	5	3	4	1	-	8
Southwest	2	2	2	2	2	2	-	4
West	7	7	6	5	5	2	2	8
State Total	34	35	27	15	21	5	4	40
Territories	2	2	2	-	2	-	-	2
Total	36	37	29	15	23	5	4	42

Highlights of State Support

- **Idaho** holds monthly meetings with RSS subgrantees to discuss contracting issues, including those related to reporting, billing, and data collection. New RSS subgrantees participate in a mandatory kickoff call and training.
- **Oklahoma** provides e-learnings on self-care, virtual monthly support meetings, and a special support call for peers who work in crisis services to ensure the wellbeing of the peer workforce. For contracted providers, the state provides a mandatory training for all supervisors of peer support staff.
- **Puerto Rico**, to ensure peer acceptance where RSS are delivered, invested in trainings for peer staff alongside clinical personnel, focused on stigma reduction and trauma-informed services. This reduces divisions between staff, and helps each person understand and value the role of other resources.

5.3.2.a. Training and workforce development

Training and workforce development programs for peer recovery personnel are supports provided by states. The majority of states (37) reported providing training, and 23 reported workforce development. States reported a wide range of approaches to deliver training, including: academic institutions; state-run learning sessions; use of peer mentors and master trainers; and statewide peer-led support organizations. For example, **Arkansas** developed a model for peer recovery with a three-level credentialing process allowing peer specialists to advance in their profession: Core Peer Recovery Specialist; Advanced Peer Recovery Specialist; and Peer Recovery Peer Supervisor. **Kentucky** offers enhanced SUD peer support training that equips peers with knowledge and skills specific to topics such as multiple pathways to recovery, motivational interviewing, and recovery planning; funds the Recovery Oriented Training and Technical Assistance Center for individuals with SUDs; and maintains a statewide Center for Peer Excellence.

5.3.2.b. Capacity-Building

Twenty-nine states reported providing capacity and organizational development to peer-led organizations that had not previously received state funding. States also offer support by providing technical assistance (37 states) and toolkits (15 states). The content of this support is often focused on business practice assistance for organizations with minimal or no previous state funding. Eleven states specifically recognized the need for technical assistance with RCO business practices such as accounting and billing procedures to better fulfill state contracting requirements. The capacity development was offered in some instances directly by the state, but many states have funded third-party or peer-based organizations to provide technical assistance and support to newly funded RSS programs. **Georgia** funds the GA Substance Use Council to provide technical assistance on contracting infrastructure and business practices. Similarly, **Indiana** and **New York** both contract with independent third-party national and local peer-led organizations for technical assistance relative to data and business practices; **Maine** offers similar support through a 'lead RCO' that assists smaller peer organizations in the state. At least two

states (**Texas** and **Rhode Island**) provide a Leadership Fellows Academy to support leadership development and adaptive leadership skills necessary to run sustainable organizations and increase their efficacy. Other states (**New York** and **New Hampshire**, for example) contracted third parties on behalf of the state agency to support regional learning collaboratives for peer-led organizations. The specific focus of capacity development activity reported includes business practices; financial sustainability; quality assurance; and workforce development.

5.3.2.c. Targeted Technical Support

In several interviews, we learned about technical support offered by states for new RCOs which simultaneously addressed underserved populations including BIPOC, Indigenous, Latinx, LGBTQIA+, and other underserved populations. **Ohio** has established a Diversity and Cultural Competence work group (50 champions from across the state) to focus on extending state support for underserved populations.

5.3.2.d. Dedicated Staff/Divisions

Twenty-one states indicated that they have dedicated state-level staff members or formal divisions, including at the executive management level, assigned to support and oversee RSS and RCOs. All 10 of the in-depth interview states have departments/divisions with multiple staff responsible for RSS support. In addition to these formal departments/divisions, the long-term support of and involvement with RSS from SSA directors was explicitly noted in **Georgia**, **Washington**, **New York**, and **Puerto Rico**; while direct legislative support for RSS was noted in **Colorado**, **New York**, **Washington**, and **Oregon**.

5.3.3. Barriers to State Support

States' ability to provide explicit support to local vendors that deliver RSS may be limited by four different factors:

5.3.3.a. Laws, regulations, and standards intended to prevent conflicts of interest and assure fairness as well as sometimes specifying payment methods

All government agencies must adhere to procurement standards and practices designed to deter 'favoritism' and to ensure fairness in the procurement process. These processes are intended to guarantee the highest standard of product or performance at the most reasonable cost. However, responses to interviews, as well as comments in the survey, note that these well-intentioned standards and practices also have the unintended effect of favoring larger, more experienced providers over smaller, startup providers often representing people in recovery, BIPOC, and cultural-, language-, or gender-diverse populations. These standards also restrict communication between states and potential vendors in the planning and process of procurement. Such restrictions may appear to prohibit engagement of the community in the funding of RSS.

5.3.3.b. Under-resourced SSA agencies bound by caps or other limitations on state employees needed to perform functions related to RSS funding and support

The number and level of state employees authorized in each SSA defines the total capacity of the state's SSA. As functions are added to the agency's role, a corresponding increase in human resources is needed, but not always authorized. Thirteen states referenced capacity limitations such as state hiring freezes, FTE 'caps,' or staff vacancies as factors that limited their ability to support all the functions required to deliver fully accessible, high-quality

RSS. As context, 31 states also referenced what is now recognized as a national issue of workforce shortages at the service delivery level.

5.3.3.c. Insufficient coordination in state agency response to common/shared vendors

As noted, RSS are funded by multiple federal funding streams channeled through several agencies at the state level. The most common example is Medicaid and block grant funding channeled through an SSA and a Medicaid agency, but additional agencies include state departments of education, corrections, judicial/courts, and housing, among others. Each of those state agencies may be funding recovery coaches, facilities, or other services that require coordinated responses to build a common vendor's capacity and infrastructure, as well as to avoid overlaps and promote complementary functions. The interviews and comments indicated a need for federal (SAMHSA, the Health Resources and Services Administration [HRSA], CMS, the Centers for Disease Control and Prevention [CDC], Department of Justice [DOJ]) and state (SSA, Corrections, Health, Education, Medicaid) agency alignment relative to RSS support. Uncoordinated funding leads to potential duplication, confusion for providers, inconsistent standards, challenges in reporting data and measuring outcomes, and complex billing processes for services.

5.3.3.d. Lack of uniformity in location of RSS within the SSA and location of SSA in the organizational structure of the larger state government

Little is known about the extent to which RSS is a top priority among many competing priorities and interests at any specific time, in any given state administration. While no explicit question was asked about this factor in either the survey or interview guides, the high response rate to our survey and interview (44 states and territories responded to one or both) is an indication of significant interest in this topic. It was clear that RSS was a top priority in several of the 10 states interviewed. In **Washington**, the SSA and Medicaid directors worked together and had active legislative support to make RSS a coordinated hallmark of the functions performed by each agency. In **Oregon**, a special grassroots legislative initiative formed a full peer recovery support funding mechanism, led by peers. The Oversight and Accountability Council that distributes the RSS funds has a majority membership from the recovery community. These cases show how legislative initiative, personal values, and advocacy can all be factors in raising RSS among competing state priorities.

5.4 Accountability

Accountability is the assurance that stakeholders are receiving the goods or services that were intended to be delivered, and that these are generating the intended results. In this instance, stakeholders include people who are to receive a service, the state that arranges and pays for some of the services, and SAMHSA and Congress, which authorize and administer the SABG as well as discretionary funds. "Receiving what is intended to be delivered" assumes that there are definitions and specifications that describe the deliverable, including the standards or quality level of that deliverable; mechanisms to report and monitor the deliverable (how much, to whom, etc.); and finally, empirical evidence that the deliverable is effective.

5.4.1. Accountability: What are States Doing?

As shown in **Table 15**, a majority of states indicated on their survey as well as in interviews, that they have operational definitions for some types of recovery support services.

Table 15. States that Reported Operational Definitions

Region	Recovery Housing	RCO	Recovery Coaching	Peer Recovery Service	Other	States that Responded
NE	9	7	6	8	1	10
SE	5	4	4	7	2	8
MW	5	3	4	5	3	7
SW	3	4	2	4		4
W	8	4	5	5	1	8
Total States	30	22	21	29	7	37
Territories	1	2	1	2		2
Total	31	24	22	31	7	39

While [Access to Recovery \(ATR\)](#) defined a menu of services for RSS, this list should be revised to reflect the current array of RSS as the field has continued to evolve and expand to include new and innovative RSS that are funded. While a generally accepted definition is “non-clinical supports often provided by individuals who are in recovery themselves, that assist individuals in initiating and sustaining recovery from an SUD,” the specific activities, interventions, and functions included in ‘non-clinical supports’ are all-encompassing.¹² RSS service lists often include such diverse categories as: job responsibilities (e.g., recovery coaching); physical environments (e.g., recovery housing or recovery community center); communication mechanisms (e.g., warm lines, telephone hotlines); activities (e.g., expressive arts, outreach); basic needs (e.g., food, financial aid); and other broad categories (e.g., family support services, crisis response, and harm reduction).

More than two-thirds of the states that responded on surveys reported that they collected performance data such as number of individuals served, number of services provided, number of certified peer specialists, and number of people referred to services (see **Table 16a**). More than half the responding states reported having ‘outcome data’ such as gained employment, secured stable housing, improved quality of life, and reduced substance use (see **Table 16b**). The format, frequency of report, analytics, and use of data identified in both the survey and interviews is not known. **Colorado** referenced the use of a ‘coding manual’ used by vendors to bill for specific RSS services. The implication of a coding manual is that services have been delineated and defined to be coded. This coding manual is used and owned by the state Medicaid authority but is also used by the SSA in its contracts. Information from the in-depth interviews indicated a paucity of data on RSS because there was no data collection requirement or list of standard data elements associated with SABG, and only Government Performance Reporting Act (GPRA) reporting associated with SOR or other federal discretionary-grant-supported RSS. The GPRA was often noted as a challenge for RSS providers who felt that the level of detail in the tool and reporting requirements conflicted with a recovery service delivery model.

Tables 16a and **16b** reflect metrics that states are collecting for all RSS services, regardless of funding stream. Many of these data points are also collected via GPRA every six months.

Table 16a. Data Metrics

Region	No. of Individuals	No. of Services	No. of Certified Peers	No. of Ind. Referred to Services	Does not apply	# States that Responded
NE	11	7	9	6	1	12
SE	7	8	8	6		8
MW	7	5	6	2		7
SW	4	4	4	2		4
W	9	8	7	5		8
State Total	38	32	34	21	1	39
Territories	2	2	2	2		2
Total	40	34	36	23	1	41

Table 16b. Data Outcomes

Region	Reduct. in Substance Use	Gained Employment	Stable Housing Secured	Improved Quality of life	Does not apply	Other	# States that responded
NE	3	6	7	3	2	2	9
SE	4	5	5	6	2	-	8
MW	5	7	7	4		1	7
SW	3	4	4	3		1	4
W	6	6	5	5	1	1	8
State Total	21	28	28	21	5	5	36
Territories	1	1	1	1		1	2
Total	22	29	29	22	5	6	38

To the extent that states do have written specifications useful for tracking, reporting, and monitoring the impact of RSS activities, they are likely different for each state. At this point, no federal agency or national organization has a uniformly accepted and standardized set of definitions, or accompanying specifications and standards for programs that support RSS activities. One current national RSS

data collection effort is Recovery Data Platform (RDP), a proprietary, cloud-based electronic data record platform available to RCOs for licensing by Faces and Voices of Recovery with 400 data points, including the Brief Recovery Capital Scale.¹³ RDP had 750 license holders by the end of 2021, representing RSS, treatment, and related organizations. Records can be used by license holders for communication, fundraising, outcome tracking, and case management purposes.

Given the absence of uniform specifications for services, and limited data reporting about those services, the ‘effectiveness question’ (Does the service accomplish what is intended?) is primarily answered anecdotally. For example, two states, **Texas** and **Washington**, have looked at the RSS data the state has accumulated to suggest potential uses and related improvements. Texas contracted with University of Texas, Austin, Addiction Research Institute to assess its RSS program, using reported data to determine outcomes.¹⁴ The assessment showed improvements in housing, employment, abstinence, and health care utilization. The Washington State internal research group reported seeing “good outcomes” in its foundational community support services (housing/employment). A national assessment of available research, conducted in 2018 on behalf of SAMHSA by the National Council of Behavioral Health and Massachusetts General Hospital Recovery Research Institute, found strong empirical evidence for mutual help organizations, and moderate to low evidence for five other categories of RSS, including: RSS in clinical settings; recovery residences; peer-based recovery support services; recovery community centers; and education-based RSS. The assessment called for clear, simple data reporting and the use of that data in expanded research efforts. The need for uniform data to track outcomes was highlighted in survey comments, where **Maine** among several other states noted the need for “universal data collection tools (not GPRA) to measure activities and outcomes.”

Given the relatively early stage of development of RSS, the path to greater accountability (Is the service delivering what was intended and having the intended effect?) has many manageable challenges ahead. The most basic is the need for a widely accepted standardized menu of services and accompanying definitions. Reporting, assessing, and using data all depend on this tool. Given lack of standard definitions, there are no current incentives or directives beyond the limited application of GPRA for vendors to report and use data. With good data reported, it would be possible to employ rigorous methods to track, monitor, and assess the impact of providing services.

5.5 Legislative/Regulatory

Development and funding of any service purchased by state government is affected by both the legislative and executive branches. Legislatures authorize or prohibit state practices, promulgate rules that the executive branch implements, appropriate funds, and provide guidance to state agencies through a variety of means (e.g., codicils, provisos). While most of the information-gathering in this project focused on state administrative functions for purchasing, payment, and provider capacity, in the course of conducting the targeted interviews TAC learned about several legislative initiatives that bear mention.

In **Colorado**, the legislature has been active over the last few years in encouraging RSS, mandating the development of a statewide strategic plan for RSS, and addressing Medicaid coverage of peer support services. In 2018, the legislature requested the development of a strategic plan for recovery support services and assigned the task to the Colorado Consortium for Prescription Drug Abuse Prevention. The SSA partnered with the Consortium and funded the needs assessment and strategic plan using SAMHSA State Opioid Response grant dollars in building the plan, and the Recovery Advisory Committee of the Consortium engaged nearly 400

Coloradans with lived experience and their allies to develop the plan. The Advisory Committee identified three strategic objectives: 1) Create a recovery-oriented system of care; 2) Provide recovery-oriented clinical care; and 3) Equip communities with recovery support.

As a companion to **Oregon's** ballot initiative to decriminalize cannabis and create a cannabis tax to fund recovery support services, SB755 requires the Oregon Health Agency to establish an Oversight and Accountability Council with a majority membership from the recovery community that would distribute funds to behavioral health resource networks. These networks would provide access to one or more of the following services: low-barrier SUD treatment and recovery services; peer support and recovery services; housing for individuals with SUD; harm reduction services; and incentives, training, and supports to expand the behavioral health workforce. Funds for the current biennium total \$300M.

In **Washington**, SB5476 requires the Health Care Authority to establish a substance use recovery services advisory committee that will inform the development of the substance use recovery services plan. The plan will include measures to assist persons with SUD in accessing outreach, treatment, and recovery support services that are low-barrier, person-centered, informed by persons with lived experience, and culturally and linguistically appropriate. Each Behavioral Health Administrative Service Organization must establish a recovery navigator program to deliver community-based outreach, intake, assessment, and connections to services for individuals with an SUD who encounter law enforcement or other first responders.

In the area of regulatory advances, the **Texas** Health and Human Services Commission is collaborating with the University of Texas, the Institute of Excellence in Mental Health, and the Council on Accreditation of Peer Recovery Support Services to pilot an accreditation project that will create and define standards for organizations that provide peer and recovery services. This will further develop the capacity of consumer-operated and community-based recovery organizations by ensuring fidelity to best practices and standardized services. **Indiana** has contracted with Faces and Voices of Recovery to work with the statewide RCO to develop certification standards for RCOs and regional hubs. In another state, the RCO association is developing standards of practice and proposing accreditation recommendations to the SSA, while several states are beginning to certify recovery housing.

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6. Essential Elements: State Support for RSS

This analysis of state expenditures and practices for RSS/RCOs made many references to specific state characteristics and practices that may be considered necessary supports for recovery support services and recovery community organizations. Prescribing a singular, uniform, ‘ideal model’ of RSS for states to follow is neither wise nor possible for two reasons. First, though RSS/RCOs have been funded for approximately 25 years, and notable researchers such as William White and John Kelly have established a foundation of evidence that supports the efficacy of RSS across the continuum of care ([See Appendix H](#)), the approaches to and components of RSS have nevertheless continued to evolve, and states supported more innovative practices to enhance recovery. Therefore, new research efforts should focus on conducting system assessments, and on evaluating the efficacy of these innovative strategies. Second, the structure and process, cultures, and population needs are different in individual states, territories, and native governments. However, a sufficient number of promising practices were identified to suggest elements that may be essential to states’ role in promoting recovery support services for residents with SUDs. The elements that follow are intended as guideposts for states to consider, and for SAMHSA to support, rather than as absolute standards.

6.1 Leadership and Visibility

Leadership makes a difference.

Leadership from the executive branch — especially the Governor’s office, the Single State Agency, and Medicaid, but also related agencies such as corrections, housing, and education — is an essential element. Leadership within the legislative branch is also important to providing the enabling and policy directions that support RSS. The leadership element involves both reasonable knowledge about RSS, and a visible indication that RSS is important, such as recognizing authentic community engagement.

6.2 Planning and Decision-Making

Mechanisms to engage and meaningfully involve people in various stages of recovery in assessing needs, planning, and execution of recovery support services make a difference.

Meaningful engagement does not mean ceding legally established decision-making responsibilities. It does mean hearing and using the advice that is offered to ensure that needs are identified; strategies to meet those needs are effective; and mechanisms to deliver the strategies are accountable (doing what is intended). Mechanisms vary widely and may include regional forums, focus groups, statewide monthly meetings, or combinations and variations of these forms.

6.3 SSA Capacity

Designated staff responsible for RSS, preferably at the executive management level, make a difference.

State functions such as public education, needs assessment, stakeholder engagement, program planning, and monitoring require dedicated full-time staff. Hiring freezes and staffing caps, while a reality in some states, impede the ability to adequately perform these functions. Identifying RSS staff as part of ‘executive management’ demonstrates the importance placed on those functions.

6.4 Coordinated Financing of RSS

The coordinated use of federal block grants, state appropriations, and Medicaid funds to pay for RSS makes a difference.

Intentional coordination between SABG, state-appropriated funding, and Medicaid funding sources takes advantage of the rules and regulations that accompany each source of funds. Using Medicaid for medically appropriate services for low-income beneficiaries frees up SABG funds for non-medical services, and leaves state funds to support needed activities ineligible for federal funds. Further coordination or intentional braiding of funds from other sources, e.g., HRSA or CDC, to state health or housing agencies or state correction agencies, optimizes the impact of funds on available services.

6.5 Purchasing RSS

Encouraging and enabling the purchase of RSS from vendors that include peers in recovery makes a difference.

While many RCOs have been in existence for decades, the evolution of the field has led to growth of newer RCOs and RSS providers. Many states are intentionally focusing efforts to fund RCOs in under-served and marginalized communities and these RCOs may lack state vendor experience and resources. A variety of approaches such as ‘first time capacity grants,’ third-party capacity development learning collaboratives, or intermediaries that provide administrative support and operational subcontracts are approaches that simultaneously expand the pool of bidders while maintaining purchasing integrity.

6.6 Support for RSS Delivery

Delivering training, technical assistance, and other supports to personnel and organizations providing RSS makes a difference.

Because peer recovery support is an evolving and expanding SUD service, the roles and responsibilities of peers and peer-run organizations are changing requiring staff training, technical assistance and organizational capacity building. The investments made in supporting RSS vendors improves the quality and sustainability of RSS providers, and expands the reach of recovery support in the community.

Technical assistance and training are standard functions of SSAs that vary widely in amount and form. Other supports may include organizational arrangements and partnerships that separate the burdens of business operations from service delivery offered by peer personnel and organizations. States’ concern for and assurance of the capacity, sustainability, and effectiveness of both peer recovery personnel and organizations is required to ensure that these resources remain state vendors for RSS.

6.7 Accountability

Standard definitions and specifications that allow RSS services to be purchased, tracked, reported, and evaluated make a difference.

Almost all states reported having ‘service definitions,’ and having data collected about services delivered. This project did not ask for state-specific service definitions. No federal agency, including SAMHSA, has a standard set of service definitions, or a taxonomy that classifies and specifies recovery support services in units that can be tracked, reported, and evaluated.

The absence of standard definitions and reporting requirements for data elements, means that states rely heavily on a combination of process indicators (e.g., number of contacts) and anecdotal data (e.g., “We visited three families in which a member overdosed, and two of them are now in stable housing”). States and payers require clarity on the structure and value of services to sustain investments in RSS. In order to target resources effectively, they will need to understand, for example, who benefits from a visit to a recovery café, what transpired in that visit, and what the benefit looks like.

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7. Recommendations and Next Steps

This is the first systematic report on states' support of RSS, and represents truly exploratory research — that is, an investigation that describes the current lay of the land, without reference to either a previous benchmark or explicitly prescribed standards. The recommendations that follow are based on findings from the referenced data sources and comments from our subject matter expert discussions. These recommendations, while intended for SAMHSA, are in many cases also applicable to states. Each recommendation is followed by possible next steps that may be taken independently or in a coordinated fashion by the PR CoE; SAMHSA; states, individually or in association; and other stakeholders.

Recommendation 1

Institute a requirement that states report the amount of Substance Abuse Block Grant and discretionary grant money spent on recovery support services, and, further, that SAMHSA identify approximately five broad domains or categories of RSS that capture the type of functions/services that make up the total expenditure.

Next Steps for Recommendation 1

At minimum, the state survey of financial expenditures should be continued, preferably on an annual, but at least biennial basis, to build a reference point to draw conclusions about levels and methods of state spending for RSS.

The state expenditures reported in this study are the first picture of how much money, in total and on average, states are spending for RSS. The study reported the categories of services purchased; the methods used to purchase these services; and the type of vendors chosen to deliver services. There is no benchmark to use to draw conclusions about the adequacy of the expenditures or the degree of variation in expenditures controlling for SUD prevalence. Consistent follow-up with a standard set of questions will build the needed reference point to determine adequacy of expenditures and of the methods employed to deploy these resources.

Recommendation 2

Both states and local RCOs highlighted the need to expand the applicant field for competitive discretionary grants and provide infrastructure support for new organizations, focusing on new agencies serving underrepresented populations through creation of tiered funding models.

Establish a tiered funding model for discretionary grants similar to tiers found in National Institutes of Health funding, in order to facilitate the funding of previously unrepresented recipients, the tiers should evaluate with distinct criteria:

- Previously unfunded applicants
- Grassroots, community-based nonprofit applicants
- New applicants that represent and promote access for diverse populations and promote equity and inclusion
- Administrative service organizations that provide business administrative functions to peer-led grassroots service delivery organizations

Next Steps for Recommendation 2

The first step to increase diversity in discretionary grant funding awards is to conduct an assessment to identify characteristics of applicants and awardees. For example, determine how many grantees for provision of RSS are first-time vs. repeat grantees and analyze “what are the characteristics of rejected applicants?” This analysis would establish a baseline and provide data to develop models for differentiated or graded discretionary grant-making that are applicable to SAMHSA and states. The models would address different grant purposes (e.g., service and administrative support or demonstration and pilot efforts). Different categories of applicants should be recognized in such models (e.g., academic and governmental entities, endowed institutions, and previously unfunded grassroots community-based organizations). The effort would start by reviewing National Institutes of Health (NIH) discretionary grant models, which include ‘new investigator’ grant programs that provide guidance through mentors. The models would provide support opportunities for RSS peer-run organizations that cannot effectively compete with larger established vendors for discretionary federal and state grants.

A specific model of funding needs to be developed for administrative service organizations. States can support and adopt this model to perform “back office functions” such as accounting, purchasing, technology support, and human resources management for local independent peer-operated service vendors. Consolidating “back office functions” would save dollars spent replicating these functions in multiple small vendors; as well as freeing vendors to use dollars for direct service supports.

Recommendation 3

Provide support for technical assistance, mutual learning, and training to states. Multiple forms of support may include: tool kits, learning collaboratives, targeted topic convenings, targeted topic training series, and specialized consultation. These forms of federal support to states can advance best practices; optimize state expenditures, purchasing approaches, and payment policies; and ensure equitable access to RSS, especially for underserved geographic areas and populations and previously unfunded providers of RSS. Such support could also assist states in developing efficient methods for providing technical assistance to newly funded organizations and in creating a sustainable funding plan for these providers.

Next Steps for Recommendation 3

Develop a toolkit for states, the content of which builds on essential elements that make a difference: leadership; planning; peer engagement; reaching diverse and underserved

populations; purchasing approaches; reporting elements; and exemplary practices.

Develop a forum (conference, learning collaborative, or regional meetings) that brings together designated recovery support staff in state SSAs for mutual support and learning.

Develop content, to be delivered in learning collaboratives and other formats for state SSAs, focused on optimizing funding for state-supported RSS. Content would focus on the coordinated use of SABG, Medicaid, and other federal and state discretionary funds; purchasing and contracting strategies; and payment options. Content could also address the development of sustainability plans for newly created organizations, based on a state's financial capacity and efficient operating models for small providers.

Develop content, to be delivered in multiple formats, that focuses on models and benefits of peer engagement in planning, deployment, and assessment of RSS.

Convene states and related subject matter experts to explore feasibility and related models of performance-based contracts and payment for RSS. This contracting model would ensure the incorporation of effective practices delivered to support appropriate persons at their particular stage of recovery.

Recommendation 4

Establish a representative consensus process that develops a taxonomy of RSS useful for reporting performance and outcomes. The taxonomy should identify major domains; essential components of each domain; key indicators of the components that can be tracked, reported, and accounted for; and illustrative examples of services or functions that represent those components.

Next Steps for Recommendation 4

The absence of standard definitions and specifications for recovery support services is a significant obstacle to the development of recovery support. Without uniform definitions, it is not possible to accurately account for:

- What was done (how many dollars? on what services? how many services? etc.)
- Who benefited from what was done (number and type of clients who received different supports and other indicators of performance).
- Who delivered the benefits (type of organization paid to offer the support)
- Whether the delivered support accomplished what was intended (what did the support accomplish, or outcomes)

To address this task, SAMHSA could engage the National Quality Forum (NQF), a congressionally chartered and effective mechanism. NQF is experienced with organizing broadly representative and diverse panels to gather and review current evidence and standards and with analyzing, synthesizing, and reporting findings (see for example: NQF: National Voluntary Standards for Treatment of Substance Use Conditions. ISBN 1-933875-09-7).

A taxonomy that includes domains, domain-essential components, and operational

indicators provides the ability to uniformly report on what was delivered to whom, and with what result. State programs (Medicaid and SSA), federal agencies (SAMHSA, HRSA, and CDC), and researchers (supported by NIH) can use the taxonomy to compare and measure consistent units and categories of services to establish performance and outcomes.

Recommendation 5

Establish a Federal Interagency RSS Coordinating Council that agrees to use standard definitions for RSS; uses standard reporting categories and units for RSS; and develops a strategy to braid available funding for RSS to promote optimum coverage and efficiency, and avoid duplication. Members should minimally include: SAMHSA, the National Institute on Drug Abuse (NIDA), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), CMS, HRSA, Department of Justice (DOJ), Housing and Urban Development (HUD), Department of Labor, and CDC.

Next Steps for Recommendation 5

SAMHSA or the Office of National Drug Control Policy may call an initial exploratory meeting for federal agencies currently funding and supporting RSS, including NIAAA, NIDA, CDC, CMS, and HRSA to, at minimum, seek opportunities to optimize funding and employ standard definitions for services and reporting results.

Recommendation 6

An update of the systematic review of RSS effectiveness presented to the SAMHSA Recovery Research and Evaluation Technical Expert Panel in 2018 is appropriate. The summary report of this Panel put forth recommendations to expand recovery research and to collect practice-based evidence from RSS providers and service users. An updated review incorporating both sources of information could bring stakeholders together in creating consensus to establish a forward-looking research agenda. Such consensus would support NIDA's recognition of the "urgent need for science to inform evidence-based approaches to recovery support, which can take multiple forms and may require different supports at different times — from behavioral coping strategies to secure housing, employment, and transportation."¹⁵

Next Steps for Recommendation 6

For many, it is an article of faith that RSS make a difference in every stage of recovery. The review of evidence to date provides some basis for confidence in that belief, with the advisory that more research is required. The last survey of the state of recovery support research was conducted in 2018. The time since then has been a period of great expansion of RSS, stimulated by the twin epidemics of COVID and opioid misuse. Federal agencies, through a coordinating mechanism or NIDA, can convene a set of diverse RSS research and practice professionals to outline a relevant research agenda; simultaneously, the 2018 meta-analysis of RSS research effectiveness should be made current.

Recommendation 7

The new Office of Recovery should establish and clarify SAMHSA's vision for RSS. This vision should specifically illuminate the current distinction between RSS for mental health and for SUDs. While some states are braiding funding for mental health and substance use to support RSS and supporting an integrated approach, there appear also to be conflicting views that support separation of the two systems.

Next Steps for Recommendation 7

As with several other recommendations, next steps in achieving a vision and creating necessary distinctions requires an authentic process of community engagement. Collaborating with stakeholders across multiple domains is a consensus building process that will foster the necessary buy-in to support the vision.

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8. Opportunities for States

8.1 Finance

From both the SSA survey and targeted interviews, it is clear that state activity in the RSS/RCO space is exciting and fast-paced, creating multiple new demands on SSAs and their staff. States have embraced their work in this area, accelerating efforts to disburse all the supplemental federal funding that became available during the last few years. They may wish to periodically assess the new funding patterns and evaluate them for the future.

8.1.1. Develop a system to assess the need

States could formalize a system to assess the need for RSS/RCOs in terms of type of services, target populations, and provider organizations. A modest process for creating an inventory of current RSS/RCO spending by service and organizational type could facilitate identifying and addressing unmet needs and covering gaps in coverage, e.g., service type, geography, or demographics. Since in some instances it was difficult for states to complete the financial portions of our survey, they may want to establish internal systems to track spending by service, provider, setting, and population. A system like this would also allow SSAs to incorporate spending from sister state agencies in the funding plan in order to align cross-agency efforts by developing complementary purchasing plans.

8.1.2. Evaluate and create plan for the sustainability of funds

Another area for consideration is related to the rapid growth in RSS/RCOs over the past several years. A massive influx of short-term funds through discretionary grants and supplemental, one-time funds through the block grants has made it a matter of urgency for states to develop sustainability plans. Anecdotally, we know that states have taken various approaches to the speed with which they are appropriating and spending supplemental funds. Some states have adopted a measured plan for the course of the funding through 2026, while other states have spent the funds at a pace that matches the allocation flow to the state. As noted in this report, spending by source data shows that discretionary funding makes up one-third of the total RSS spend, which are time-limited funds.

Each state may want to consider taking at least two actions. First, determine the state's "carrying capacity" for using one-time funds for RSS; this capacity would be based on an evaluation of potential funding sources that may be available "post-windfall" and a determination of estimated fund availability. Second, investigate options for small RCOs to create "economies of scale" that are not attainable with their business model. Organizations could affiliate or partner with other organizations in order to create efficiencies in their administrative functions and costs. These affiliations could be accomplished through contractual arrangements in which administrative functions are consolidated but organizational governance would remain intact. A "management service organization," for example, is owned by the participating providers. Since it is unlikely that a state will be able fully fund each small, peer-run organization, efficient operating models may be necessary so that RCOs can be sustained over time.

8.1.3. Reduce the burden through roadmaps for purchasing and payment

The SSA survey and targeted interviews both demonstrated states' efforts to create accommodations in their typical procurement and payment practices in order to reduce the burden on new, small organizations. Having gained experience with the processes, states may now want to develop a roadmap for the continuation of purchasing and payment strategies that support the stage of growth in both the state's capacity as well as that of the provider community. The roadmap could include pre-funding activities (e.g., regularly scheduled orientation sessions for new providers wishing to apply), as post-award technical assistance. Balancing "good stewardship" of public funds with an interest in bringing new types of organizations into the provider network, the state would gradually incorporate some of its traditional financial approaches so that there are comparable contracting requirements across most of the provider network. These requirements would include data collection on performance and outcomes, including the use of methods to assess the impact of RSS/RCOs on recovery.

8.2 Engagement

Information received through the survey and targeted interviews showed several areas where states are gaining traction in engaging the recovery community:

8.2.1. Dedicate management-level staff

Dedicating some management-level state staff or operating units to outreach and support for RSS enables the SSA both to understand the recovery needs of various communities and to assist RSS/RCOs after awards are made and contracts issued.

8.2.2. Establish advisory processes with majority members from the recovery community

An advisory process with the majority of members from the recovery community can help to assure that the recovery voice is amplified through sometimes competing input. Having a specific communications plan targeted to the recovery community that includes surveys, interviews, and focus groups provides regularly occurring, current feedback on state plans, policies, and priorities.

8.2.3. Consult with the statewide RCO

States have also found that ongoing consultation with their statewide RCO is a valuable source of information. States should develop specific guidelines to assure that community engagement activities are authentic, including the voices of diverse individuals with lived experience, not just those who show up.

Authentic community engagement will require that states reach out to and engage historically marginalized populations to develop trust in the process and promote diversity of perspectives. States should employ recovery community strategies to make sure that there is geographic, socioeconomic, racial, gender, and age diversity. Additionally, cultural and linguistic representation — along with engagement of various disability communities, including deaf and hard of hearing, blind, and people with intellectual and physical disabilities — are integral factors in a community that support recovery from SUD and help to define the recovery ecosystem.

8.3 State Role

8.3.1. Create a strategic vision for RSS

Based on the broad experience states have gained over the past five years, they may want to consider developing a blueprint as part of the state plan. The blueprint would outline the state's vision for RSS and describe the role of RSS and RCOs within the SUD harm reduction, treatment, recovery, and support landscape. Functions and responsibilities of statewide RCOs and hubs would be clearly articulated, describing their relationship with the SSA and with other RSS providers. As a comparison to the spending plan mentioned above, the blueprint would lay out broad priorities for RSS, providers, and populations, and would identify activities that are considered essential components of the recovery ecosystem. The strategic plan could be used to communicate the state's interests to the recovery community, stakeholders, treatment providers, and other parts of state government.

8.3.2. Provide technical assistance

A second critical role is the development of a technical assistance plan that establishes and defines state capacity for advisory groups, connection with the recovery community, support to providers on contract compliance, and capacity development. The plan would describe the scope and the limits of the technical assistance. It would include a curriculum for basic skill development that has content, phases, and an end date for both RSS providers and RCOs. Companion expectations would be established about the internal capacities an RCO needs to develop internally as it completes phases of the curriculum, possibly using digital platforms that incorporate training, competency evaluation, and performance metrics.

8.3.3. Support regulatory and consumer protection processes

Finally, states have an obligation to regulate SUD providers as part of their consumer protection function to assure that basic operating and quality requirements are met. States could consider working with their RSS/RCOs; establish some standards of practice for RSS providers and RCOs; and credential or certify some types of RSS (e.g., recovery housing, recovery community centers) through a recovery-oriented set of standards. In states where RCOs may be eligible for enrollment as Medicaid providers, qualifications for this provider type will need to be adopted.

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9. Observations for Further Exploration

Recovery support services are available to anyone, delivered through a variety of recovery community organizations supported by SAMHSA block and discretionary grants as well as HRSA, CDC, CMS, DOJ, and NIH resources, as well as state discretionary and Medicaid financing. Little to nothing is known about the insurance status of people who benefit from recovery support offered by peers in a full range of settings. What *is* known is that Medicaid pays for a defined set of RSS for eligible beneficiaries in 43 states.¹⁶ As this analysis was focused on SAMHSA expenditures, there is a void of knowledge about the extent of private insurance coverage for peer-based RSS. The implication is that SAMHSA and other public dollars may be subsidizing private insurance companies that insure beneficiaries with SUDs, for both treatment and recovery. A two-pronged analysis of private insurance coverage of RSS, and of privately insured people who use peer-based RSS, would provide insight into the extent to which public subsidization of private organizations is occurring; as well as data to support private insurance coverage of Medicaid-equivalent functions for privately insured beneficiaries.

9.1 The Peer Workforce

The cornerstone of a recovery-oriented system of care is a strong, diverse, and connected peer workforce. As states move toward developing and providing peer recovery support services (PRSS), the individuals who provide such services and supports would benefit from a comprehensive training curriculum that reflects the strategic structure and culture of the state in which they operate. SSAs currently utilize many methods to disseminate peer certification, such as conducting this process out of a state office, through a contract with a peer-run nonprofit program, or through a clinical licensing board. Whichever method is used, people providing PRSS should have a distinct set of knowledge, skills, and abilities that are reflective of the peer role. Additionally, there should be a process in place that provides ongoing and regular support and skill enhancement, such as leadership training, conducting individual recovery check-ins, running recovery groups, peer advocacy, trauma-informed care, and other activities determined to be important to both the SSA and the peer recovery community.

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10. Conclusion

Over the past 25 years, SAMHSA has made significant investments in the development, support, and implementation of RSS throughout the nation. The Recovery Community Support Program that began in 1998 and has evolved into the Building of Communities of Recovery Program, Access to Recovery (ATR), RCSP Statewide Networks grants, and now some parts of SOR all represent federal efforts to spread access to RSS to individuals in need. As the number of overdose deaths across the nation continues to swell, peers are being called upon to reach those most vulnerable and provide support to individuals across the care continuum from prevention to sustained recovery. States have engaged PWLE to develop strategies and solutions and have increased investments in multiple forms of recovery support. However, there continues to be a lack of available information on how much and where money is being spent on RSS. There is even less information available on outcomes related to RSS spending.

States have varied significantly in their approach to RSS provision and these variations present challenges to improving our understanding of the national impact of these investments. This report is an attempt to create a baseline understanding of states' efforts in order to provide direction to SAMHSA and states to optimize funding. As the field of RSS is growing and the role of RCOs in meeting the needs of individuals with SUD is emerging, a better understanding of how to support these services effectively is essential to achieve desired outcomes.

The contribution of the RCOs and the larger recovery community in transforming the approach to working with individuals with substance use disorders cannot be overstated. In many states, the grassroots evolution of RCOs and RSS seems to have resulted in an apparent disconnect from government agencies and funding. This report, in tandem with its companion paper which assesses the RCOs' needs, is intended to identify successful collaborations of SSAs with RCOs and RSS that have bridged that divide and can serve as examples for other states attempting to do the same.

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11. Appendices



Appendix A: Advisory Committee Members



- Flo Stein-Bolton, retired North Carolina Single State Authority, and past president of the National Association of State Alcohol and Drug Abuse Directors
- Greg Williams, filmmaker, and manager of the Alliance for Addiction Payment Reform, convened by Third Horizon Strategies
- Joe Powell, president and Chief Executive Officer of the Association of Persons Affected by Addiction (APAA) Recovery Community Support Center
- Mark Stringer, retired Missouri Single State Authority, and past president of the National Association of State Alcohol and Drug Abuse Directors
- Melanie Whitter, deputy executive director of the National Association of State Alcohol and Drug Abuse Directors
- Michael Botticelli, former Office of National Drug Control policy director and retired Massachusetts Single State Authority
- Patty McCarthy, chief executive officer of Faces and Voices of Recovery

Appendix B: Approaches Employed to Execute Study Methods

1.1 Stakeholder Input

The first step in the project involved connecting with organizations that could provide a context for the project. Specifically, background information calls were held with: Peer Recovery Center of Excellence and research team; the SME Panel; the National Association of State Alcohol and Drug Abuse Directors (NASADAD); the National Council for Mental Wellbeing; the National Association of State Mental Health Program Directors (NASMHPD); Faces and Voices of Recovery (FAVOR); the National Alliance for Recovery Residences (NARR); the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA); the Office of National Drug Control Policy (ONDCP); the National Institute on Drug Abuse (NIDA); the National Institute of Alcohol Abuse and Alcoholism (NIAAA); the Recovery Research Institute at Massachusetts General Hospital; and other relevant stakeholders suggested in the conversations.

Conversations with these stakeholders provided valuable feedback on the project's approach and recommendations as agreed upon with the UMKC Peer Recovery Center of Excellence (PR CoE). Specifically, the conversations accomplished the following:

- Informed stakeholders about the intended scope of the project
- Identified and gathered information about 'exemplary state practices' to support recovery services and programs, which was of help in developing recommendations for in-depth interviews
- Identified the latest research supporting effectiveness of RSS
- Identified federal and state priorities relative to the expansion of RSS
- Identified research relevant to state financial and strategic support of recovery services
- Developed stakeholders' ongoing buy-in and support for the project

1.2 Expert Advisory Committee

The context-setting conversations with stakeholders were also used to identify a small number of individuals who were invited to serve on the State Budget Analysis Expert Advisory Committee to validate questions and suggest approaches to gathering the data we sought from states and funding sources. This group helped to guide and inform methodology, instruments, processes, and analyses, and to ensure that components of the final report would be inclusive and would accurately reflect the needs of both states and the recovery service community. During both the data-gathering and analysis phases, TAC consulted with the Advisory Committee for tips on scouring state budget information in order to identify RSS funding.

1.3 Desk Review

While TAC had originally planned to review SAMHSA material from both SABG and discretionary grants, only the SABG application and related materials were publicly available. Through the Freedom of Information Act, the team made a request to SAMHSA for SOR applications and reports, but the information had not been received by TAC at the time of the analysis. TAC

reviewed each state's SABG documents through SAMHSA's online WebBGAS system. Analysis focused on the section of the application that requires states to provide a description of recovery and of recovery services for individuals with SUDs. While TAC had planned on reviewing SAMHSA documents on State Targeted Response/State Opioid Response (STR/SOR) and other discretionary grants, that information was not available. The team did, however, review the National Association of State Alcohol and Drug Abuse Directors (NASADAD) STR/SOR Profiles and SAMHSA's 2020 and 2021 reports to Congress on the SOR grants.

1.4 Structured and Recorded Exemplary State Interviews

The team conducted telephonic interviews of 10 diverse (states, territory, geographic, and Medicaid expansion) SSA representatives who were identified as champions of RSS, inquiring about their experience with administering and managing RSS funding, including stakeholder involvement in fund allocation and oversight; contracting and payment methods; performance and outcomes tracking; types of support offered to RCOs and other RSS providers; challenges faced in contracting with these providers; and successful strategies for addressing these challenges. States also provided feedback on the data gathered and the gaps identified, and provided suggestions on closing the gaps.

1.4.1. Single State Agency (SSA) Survey

Based on the experience with the desk reviews and state interviews, TAC developed a brief survey that was sent to all 50 states, eight territories/jurisdictions, one tribe, and one municipality, requesting key data elements covering RSS funding, state contracting and payment practices, challenges encountered in funding RSS, and successful strategies for addressing those challenges. The survey was distributed through REDCap which is a secure web application for building and managing online surveys and databases. Because states use various terms to describe RSS and have varying definitions for those terms, TAC developed operational definitions for the terms used in the survey and distributed that glossary with the survey.

1.5 Data Analysis

This is a mixed method exploratory analysis, reliant on content analysis, targeted interviews, and a structured survey of all states and territories. Data from the three basic sources — document/desk review, structured interviews, and a brief written survey instrument — were organized, cross-referenced, and reviewed to identify consistent themes, as well as points of divergence and variation in findings. Feedback on organizing categories was sought from the PR CoE team, the SME Panel, and the State Budget Analysis Expert Advisory Committee. The analysis organized data from the research into categories and identified both common as well as unique practices that may serve as exemplary early innovations. The resulting themes, trends, and outliers form the heart of this report and the basis for its recommendations. A draft report was prepared for review and feedback by the three groups noted above, and specific state content was reviewed by states to verify accuracy. The final report synthesizes the quantitative and qualitative information collected, using the SAMHSA and NASADAD documents, the telephonic interviews of the sample of SSAs, and the SSA survey.

Appendix C: Exemplary State Interview Guide

For the purposes of this project, the definition of “recovery community organization” is based on the work of Phil Valentine, William White, and Pat Taylor (2007), [The recovery community organization: Toward a Working Definition and Description](http://www.facesandvoicesofrecovery.org/pdf/valentine_white_taylor_2007.pdf), Faces and Voices of Recovery, http://www.facesandvoicesofrecovery.org/pdf/valentine_white_taylor_2007.pdf:

- Grassroots, nonprofit, developed and led by the local recovery community
- Advances the political and cultural mobilization of communities of recovery
- Provides recovery-focused public and professional education
- Advocates for pro-recovery laws and social policies
- Advocates for a recovery-focused redesign of addiction treatment
- Promotes peer-based recovery support services
- Supports local, state, national, and international recovery celebration events
- Promotes a recovery research agenda

Interview Questions

I. Funding Levels, Services and Organizations

SAMHSA Funded Services Information

- Which federal grant programs do you use to financially support recovery support services (RSS), including for RCOs?
- What is your annual spending on RSS from these federal grants?
- What services do you fund with these grants and which organizations? (*complete below*)

Grant	Service	Type of organization	Annual spend	If other specify here
Choose an item.	Choose an item.	Choose an item.		
Choose an item.	Choose an item.	Choose an item.		
Choose an item.	Choose an item.	Choose an item.		
Choose an item.	Choose an item.	Choose an item.		
Choose an item.	Choose an item.	Choose an item.		
Choose an item.	Choose an item.	Choose an item.		
Choose an item.	Choose an item.	Choose an item.		
Choose an item.	Choose an item.	Choose an item.		

Grant	Service	Type of organization	Annual spend	If other specify here
Choose an item.	Choose an item.	Choose an item.		
Choose an item.	Choose an item.	Choose an item.		
Choose an item.	Choose an item.	Choose an item.		
Choose an item.	Choose an item.	Choose an item.		
Choose an item.	Choose an item.	Choose an item.		
Choose an item.	Choose an item.	Choose an item.		

State General Fund Information

- Do you provide any state general revenue funding for RSS, including for RCOs? Note: do not include the state share for Medicaid spending.
- If yes, what do you spend annually for RSS?
- If yes, what services do you purchase and from what type of organization (*complete below*)

Service	Type of organization	Annual spend	If other specify here
Choose an item.	Choose an item.		
Choose an item.	Choose an item.		
Choose an item.	Choose an item.		
Choose an item.	Choose an item.		
Choose an item.	Choose an item.		
Choose an item.	Choose an item.		
Choose an item.	Choose an item.		
Choose an item.	Choose an item.		
Choose an item.	Choose an item.		
Choose an item.	Choose an item.		

- How many providers are under contract with the state to provide RSS? How many of these are RCOs?

- What other sources are you aware of that fund RSS? (*Select all appropriate*)

Choose an item.	Choose an item.
Choose an item.	Choose an item.
Choose an item.	Choose an item.
Choose an item.	Choose an item.

II. Planning, Administration, and Contracting

Policy Decisions	<ul style="list-style-type: none"> • What were the major drivers that led the state to fund RCOs and RSS? • Is there any legislation which requires funding for RSS?
Engagement	<ul style="list-style-type: none"> • To what extent was the community, particularly individuals with lived experience, engaged in the process to determine services to fund and in the oversight of services funded by: <ul style="list-style-type: none"> • Block Grant Funding: • Discretionary Grant Funding: • State Funding:
Purchasing	<ul style="list-style-type: none"> • How are funds made available for RCOs and other RSS providers? (sole source, selecting contracting, competitive procurement, other) • What mechanisms are available for a new or emerging entity to secure the funds? • What financing mechanisms does the state use and/or require for RCOs and RSS providers? (grants, fee-for-service reimbursement, cost reimbursement, performance contract, other)
Accountability	<ul style="list-style-type: none"> • Does the state have specific outcomes or trackable results that are identified, defined and specified for contractors to report? • What are the specific indicators the state uses to determine acceptable performance results from contractors? • Does the state have a reporting system that RCOs/RSS providers use to report on program participants, service activities and outcomes? • Is there any public reporting on metrics, if so, to whom?
Needs Assessment/ Gap Analysis	<ul style="list-style-type: none"> • What factors/criteria are used to determine funding allocation: geographic distribution, population demographics, SUD prevalence, other? • Are there geographic gaps in RSS in the state? Why do they exist and how is the state addressing them?
Provider Support	<ul style="list-style-type: none"> • What forms of support does the state offer to interested or emerging RSS providers? (Training, TA, capacity building support, toolkits, other)

III. Lessons Learned and Future Work

Lessons Learned	<ul style="list-style-type: none">• What have been your successes have you had in funding RSS/RCO• Have there been particular challenges with contracting with RCOs?• How would RSS providers, including RCOs, describe as the challenges they've faced in contracting with the state?• If you've faced challenges, what strategies have you employed to remove barriers to RSS providers, including RCOs, contracting with the state? What strategies have been particularly successful?
Future Work	<ul style="list-style-type: none">• What are the next steps and key activities that the state will undertake to expand and strengthen RSS?• What is your vision for the future of recovery support services in your state?
Additional Information	<ul style="list-style-type: none">• Is there anyone else with whom you would recommend speaking regarding state expenditures for RSS (i.e statewide RCO, provider association, Medicaid contact, etc.)

Thank you

TAC and the PR CoE would like to thank you for taking the time to interview with the team and supply additional information to support this process. Your input will be invaluable as the process moves forward.

Please indicate if the state has an operational definition for any of following Recovery Support Services:

- | | |
|---|--|
| <input type="checkbox"/> Recovery Housing | <input type="checkbox"/> Recovery Coaching |
| <input type="checkbox"/> Recovery Community Organizations | <input type="checkbox"/> Peer Recovery Support |
| <input type="checkbox"/> Other Definitions: Please list _____ | |

Within the broader scope of services described in the budgeting section, please select all that apply to RSS purchased by the State:

- | | |
|--|--|
| <input type="checkbox"/> Recovery Coaching | <input type="checkbox"/> Education/Vocational or Employment Assistance |
| <input type="checkbox"/> All Recovery meetings | <input type="checkbox"/> Mental Health Support |
| <input type="checkbox"/> Technology/Internet Access/Recovery apps & technology | <input type="checkbox"/> Childcare Services |
| <input type="checkbox"/> Narcan/Naloxone training | <input type="checkbox"/> Financial Services |
| <input type="checkbox"/> Recreational Activities/Active Lifestyle Events | <input type="checkbox"/> Expressive Arts |
| <input type="checkbox"/> Legal Assistance | <input type="checkbox"/> Health/Nutrition/Exercise/Wellness Activities |
| <input type="checkbox"/> Family Support Services | <input type="checkbox"/> Peer Run Respite |
| <input type="checkbox"/> Peer-facilitated Support Groups | <input type="checkbox"/> Service/treatment linkage and coordination |
| <input type="checkbox"/> Housing Assistance (Other than Recovery Housing) | <input type="checkbox"/> Warm Line |
| <input type="checkbox"/> Recovery Schools/College-based recovery programs | <input type="checkbox"/> Emergency Department Bridging/Bridging from other inpatient or residential settings |
| <input type="checkbox"/> Basic Needs Assistance | <input type="checkbox"/> Outreach |
| <input type="checkbox"/> Other (please specify): _____ | <input type="checkbox"/> Crisis Response |

Settings:

- | | |
|--|--|
| <input type="checkbox"/> SUD Treatment Settings | <input type="checkbox"/> Recovery Community Center |
| <input type="checkbox"/> Health Care Settings | <input type="checkbox"/> Recovery Cafe |
| <input type="checkbox"/> Justice System Settings | <input type="checkbox"/> Clubhouse |
| <input type="checkbox"/> Educational Settings | |
| <input type="checkbox"/> Other: Describe: _____ | |

Does the state fund any specialized RSS that focus on (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> People whose preferred language is Spanish | <input type="checkbox"/> Males |
| <input type="checkbox"/> People experiencing homelessness | <input type="checkbox"/> People who live in remote areas |
| <input type="checkbox"/> People involved in the criminal justice system | <input type="checkbox"/> Black, Indigenous, People of Color |
| <input type="checkbox"/> People with disabilities | <input type="checkbox"/> Older Adults |
| <input type="checkbox"/> LGBTQIA+ | <input type="checkbox"/> Youth and Young Adults |
| <input type="checkbox"/> Females | <input type="checkbox"/> Pregnant Women or Women with Dependent Children |
| <input type="checkbox"/> Other: Describe: _____ | <input type="checkbox"/> Families |
| <input type="checkbox"/> Please describe services selected above _____ | |

II. State General Fund Information

The level of detail requested in the chart below will help to inform our work, but for states that are not able to provide this kind of breakdown, please provide, How much funding was allocated to RSS from state general revenue?

Optional: What services do you purchase and from what type of organization (complete below)

Service	Type of organization	Fiscal year spend	If other specify here
Choose an item.	Choose an item.		
Choose an item.	Choose an item.		
Choose an item.	Choose an item.		
Choose an item.	Choose an item.		
Choose an item.	Choose an item.		
Choose an item.	Choose an item.		
Choose an item.	Choose an item.		

Other State Departments or Agencies that Fund Recovery Support Services

What other state sources are you aware of that fund RSS? (Select all appropriate)

Choose an item.	Choose an item.
Choose an item.	Choose an item.
Choose an item.	Choose an item.
Choose an item.	Choose an item.

What actions is the state taking to ensure alignment of services across agencies (check all that apply)?

- RSS taskforce, workgroup or other coordinating body
- All RSS efforts under an umbrella organization (i.e. Office of Health and Human Services)
- Purchasing mechanisms to align contracting process
- No current coordination process

Other: Describe: _____

Other Sources of Funding for RSS

What other sources are you aware of that fund RSS? (Select all appropriate)

Choose an item.	Choose an item.
Choose an item.	Choose an item.
Choose an item.	Choose an item.
Choose an item.	Choose an item.

Purchasing

How are funds made available for RCOs and other RSS providers? *(Check all that apply)*

- Sole Source
- Selective Contracting
- Competitive Procurement
- Other: Describe _____

Explain: _____

What payment mechanisms does the state use and/or require for RCOs and RSS providers? *(Check all that apply)*

- Grant
- Fee-for-Service reimbursement
- Other: Describe _____
- Cost reimbursement
- Performance Contracting

Explain: _____

What process/criteria does the state use to make funding allocation decisions? *(Check all that apply)*

- Geographic Distribution
- Population Demographics
- SUD prevalence
- Recovery Community Engagement
- Licensing and Certification Standards
- Other _____

Are there formal mechanisms for involving individuals in recovery in the decision making process for funding RSS services? If so, please describe:

- Yes
- No

Please describe: _____

Provider Support

What forms of support does the state offer to interested or emerging RSS providers? (Check all that apply)

- Training
- Technical Assistance
- Capacity building support
- Toolkits
- Workforce Development
- Other: Describe _____

Outcomes/Metrics

Does the state collect any of the following data/metrics to inform performance on RSS: (Check all that apply)

Process:

- Number of individuals services
- Number of services provided
- Number of certified peers
- Number of individuals referred to services

Other: Describe _____

Outcomes:

- Reduction in substance use
- Individuals who gained employment
- Stable Housing secured
- Improvement in quality of life assessments

Other: Describe _____

Lessons Learned

What strategies has the state employed to successfully fund RSS/RCO whether in non-traditional community based organizations or established contractors? (check all that apply)

- Technical Assistance
- Modified purchasing requirements
- Modified reporting requirements
- Community engagement in process
- Operational definition of RSS
- Support from statewide RCO network/agency
- Establish a state role focused on RSS
- Collaboration with other state systems (i.e. criminal justice, department of health, if applicable)

Other: Describe: _____

Lessons Learned (cont.)

Have there been particular challenges with contracting with RSS providers or RCOs? (check all that apply)

- Workforce Issues
- Lack of state capacity to implement oversee process
- Lack of familiarity with contracting reporting requirements
- Inability of RSS providers to meet state contracting standards
- Lack of funding for infrastructure development
- Lack of flexibility from the original funding source

Other: Describe: _____

What strategy has been the most effective in overcoming any challenges?

Do you have any lessons learned that would be valuable to include in the report to SAMHSA or in a toolkit for states?

Do you have any recommendations for SAMHSA or other federal agencies that enable states to optimize funding for RSS?

How could SAMHSA best support states in expanding and strengthening RSS within their states?

What are two or more innovative recovery initiatives in your state that you would like to share with colleagues?

Is there anything else you would like to share that was not asked in the survey?

Appendix E: State Funding for RSS Survey — Working Definitions of Terms

Generic term:

1. *Recovery Support Services (RSS)*:
RSS applies to all non-clinical supportive services aimed at supporting persons with SUD to reduce harm, access treatment and sustain recovery.

Terms Used in this Survey:

2. *Recovery Community Centers*:
The generic term referencing hubs of recovery support, centered in the hearts of communities to help build recovery capital (i.e., resources to aid and sustain recovery). These are non-residential centers that provide space for recovery support group meetings and access to recovery coaching (see above) as well as facilitating linkage to employment, training, and other social services. They also provide space for and help facilitate rewarding social community activities and community engagement.

A recovery community center may be operated by a larger organization or a single function freestanding organization.
3. *Recovery Housing*
Recovery Housing is typically peer-led and provides a substance-free and recovery-supportive, sober living environment that encourages prosocial activity. It provides strong social support, recovering role models and coaches, and ongoing inter-personal accountability and monitoring. Recovery Housing does not have a prescribed length of stay and may be used for pre-treatment, recovery stabilization and actualization, as well as post-treatment.
4. *Peer Recovery Coaching*
The provision of information, material, emotional, social supports to persons with SUD, by a trained person in recovery, employed by a recognized organization. This includes initial engagement, referral to other community supports and services, warm hand-offs, transportation, group sharing, meals, partnership with crises teams, etc.
5. *Peer workforce development*
Peer Workforce Development includes all activities that create a peer workforce through training and/or credentialing, recruitment standards, enhance the skills of the peer workforce, develop and sustain a peer supervisory system, and ongoing education to improve the capacity of the peer workforce to provide high quality peer supports.
6. *Recovery Supports*
Recovery Supports are resources provided to help build recovery capital in the areas of social determinants of health and include basic needs assistance, transportation, child care, employment assistance, etc. Recovery Supports are delivered in a culturally and linguistically appropriate manner.

7. *Recovery Community Organization (RCO)*

A formal non-profit organization whose primary mission is to provide advocacy, education and training and recovery support services, and is led and governed by a majority of people in recovery.

8. *Statewide Recovery Community Organization*

A single organization, governed by people in recovery, whose function is to provide support, such as infrastructure development, training, technical assistance or coordination to local organizations delivering recovery support services. A statewide RCO promotes recovery-focused policies, mobilizes people in recovery and allies, and supports the development and implementation of recovery services and supports in communities of color as well as immigrant, indigent and refugee communities through intentional outreach and action.

9. *All Recovery Meetings*

An alternative to 12-step meetings, “all recovery” meetings welcome individuals who struggle with addiction, are affected by addiction, or support the recovery lifestyle. The meetings offer an opportunity to focus on the hope found in recovery and may be facilitated by peer recovery specialists.

10. *Recovery Café*

Recovery cafés provide a safe space and community to anchor members (closely-supported consumers) in the sustained recovery need to gain and maintain access to housing, social and health services, healthy relationship, education and employment. Important elements are a healthy milieu, Recovery Circles that offer peer-to-peer support, volunteer opportunities that allow members to learn the rewards of giving back and linkage to community supports.

11. *Clubhouse*

Clubhouses are recovery centers that provide a restorative, non-clinical environment for young people whose lives have been disrupted by addiction to connect with others in recovery. Clubhouses are built on a core of peer-driven supports and services that help young people progress in their recovery, by encouraging a drug-free lifestyle. They use evidence-based prevention strategies and offer a variety of services and activities, including tutoring and help with homework, college and job preparation, community service opportunities, peer mentoring, and sports, fitness and group entertainment activities.

Appendix F: Summary of Narrative Responses

Survey Question: Do you have any lessons learned that would be valuable to include in the report to SAMHSA or in a toolkit for states? Thirty states and territories responded to this survey question. The most frequently cited lesson learned (11 states) was recognition that in order to be able to fulfill contract requirements, RCOs need technical assistance in how to operate the business side of providing supports to the community, including the use of sound accounting and billing practices. Next, five states and one territory highlighted the need for training and TA to improve the quality of care, including training in supervision of certified peer recovery support staff. Three states and one territory identified the need to offer culturally competent and appropriate recovery supports. Three states identified the importance of including people representative of the populations served in decision-making processes at the state governance and funding allocation levels. Another three states also referenced the importance of adopting operational definitions of recovery support services as an important lesson learned.

Survey Question: Do you have any recommendations for SAMHSA or other federal agencies that enable states to optimize funding for RSS? Thirty-one states and territories responded to this question. The most frequently cited recommendation (10 states), requests that SAMHSA institute greater flexibilities in how its funds can be used to cover RSS. For example, states request greater flexibility to use both SABG and MHBG funds as needed and in categories of RSS that the states deem necessary. Also, one state requests greater flexibility to use SOR funds for SUD populations that may not have opioid use disorders (OUDs). Five states recommend that SAMHSA create sustainable and predictable funding streams that will support a range of recovery support services. Examples of areas needing sustainable and predictable funding included capital improvements; recovery supports in criminal justice settings; and funding for peer supports, recovery housing, supported employment, and peer respite programs. Five states recommended that SAMHSA develop a federal definition of RSS terminology, citing the need to have consistency across programs and states for the purpose of evaluation of service quality and outcomes. Three states recommend that SAMHSA create dedicated funding for RSS, also referenced as an RSS set-aside, and an additional three states recommended that SAMHSA support states in the creation of state-level infrastructures to support the oversight of RSS programming.

Survey Question: How could SAMHSA best support states in expanding and strengthening RSS within their states? Thirty-two states and territories responded to this question. The two most frequent responses were that more funding (13 states) is needed to support RSS and infrastructure to effectively manage it, and that more training and technical assistance (11 states and territories) must be made available to states. Areas highlighted for more training and TA included creating partnerships, workforce development, infrastructure support, integration of services, strategic planning, capacity-building, and planning for sustainability. Five states request that SAMHSA sponsor a learning community to bring states and RCOs together to learn more about business administration, innovative practices, and lessons learned on how federal funds can be optimized. Three states request that SAMHSA provide more clarity on reporting requirements and tracking the performance of RSS.

Appendix G: RSS Funding for Targeted Populations

Region	People whose preferred language is Spanish	People who are experiencing homelessness	People involved in the criminal justice system	People with disabilities	LGBTQIA+	Females	Males	People who live in remote areas	BIPOC	Older Adults	Youth and Young Adults	Pregnant Women or Women with Dependent Children	Families	Other	Number of States that Responded
Northeast	1	6	11	2	3	5	4	2	4	1	4	8	2	1	12
Southeast	1	5	8	3	–	7	5	6	3	2	6	7	4	–	9
Midwest	1	6	6	1	–	3	2	2	3	–	3	4	2	1	8
Southwest	2	4	4	3	3	2	2	2	3	2	4	4	4	1	4
West	3	5	9	2	4	2	1	6	6	1	4	4	5	1	9
State Total	8	26	38	11	10	19	14	18	19	6	21	27	17	4	42
Territory	1	2	2	1	1	1	1	1	1	1	1	1	1	–	2
Total	9	28	40	12	11	20	15	19	20	7	22	28	18	4	44

Appendix H: Articles Reviewed

- Ashford, R. D., Brown, A., Canode, B., Sledd, A., Potter, J. S., & Bergman, B. G. (2021). Peer-based recovery support services delivered at recovery community organizations: Predictors of improvements in individual recovery capital. *Addictive Behaviors*, *119*, 106945. <https://doi.org/10.1016/j.addbeh.2021.106945>
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- Kelly, J. F., Greene, M. C., Bergman, B. G., White, W. L., & Hoepfner, B. B. (2019). How many recovery attempts does it take to successfully resolve an alcohol or drug problem? Estimates and correlates from a national study of recovering U.S. adults. *Alcoholism, Clinical and Experimental Research*, *43*(7), 1533–1544. <https://doi.org/10.1111/acer.14067>
- Kelly, J. F., Stout, R. L., Jason, L. A., Fallah-Sohy, N., Hoffman, L. A., & Hoepfner, B. B. (2020). One-stop shopping for recovery: An investigation of participant characteristics and benefits derived from U.S. recovery community centers. *Alcoholism, Clinical and Experimental Research*, *44*(3), 711–721. <https://doi.org/10.1111/acer.14281>
- Medicaid and CHIP Payment and Access Commission (2019). Recovery Support Service for Medicaid Beneficiaries with a Substance Use Disorder. retrieved from <https://www.macpac.gov/publication/recovery-support-services-for-medicaid-beneficiaries-with-a-substance-use-disorder/>

Myrick, K., & Del Vecchio, P. (2016). Peer support services in the behavioral healthcare workforce: State of the field. *Psychiatric Rehabilitation Journal*, 39(3), 197–203. <https://doi.org/10.1037/prj0000188>

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Appendix I: Promising Practices Identified in State Survey



Alabama: ROSS (Recovery Organization of Support Specialists) has developed a mentorship program in order to grow the peer workforce. In order to qualify as a certified recovery support specialist in Alabama, the person must have two years of continuous demonstrated recovery time from a substance use disorder. ROSS developed a program where individuals with 12 months of recovery time could enter a mentorship program so that by the two-year mark, they were fully trained and ready to work as a peer in this field.



Alaska: The state established a traditional peer support certification within the peer support certification. This is a specialized certification that incorporates native traditional healing within peer support services.



Arizona: The Managed Care Organizations are required to hold community engagement sessions to identify barriers and needs. The state leveraged targeted investment opportunities to enhance the ability to provide peer supports to those that were exiting an incarcerated setting. This service has supported those engaged to have connection to integrated medical and behavioral health services at the time of release when they need services the most and helps to decrease recidivism.



Arkansas: The state developed their model requiring Peer Supervision instead of clinical supervision. Initially they received a lot of push back. Continued training and presentations on the importance of role clarity made the transition successful. The Arkansas Peer Specialist Program (APSP) is an innovative three-tiered credentialing process that allows an individual the opportunity to progress through the core, advanced and supervision levels of The Arkansas Model.



Colorado: Integrating funding for RCOs with their funding mechanism (regional Managed Service Organizations) who are also responsible for funding treatment services has been key. Not everyone who gets treatment will want RSS from RCOs and not everyone who gets RSS from RCOs will want or need treatment, but with an integrated system as a full continuum, are maximized opportunities for partnership and cross referrals. The state expanded evidence based Individual Placement and Support (IPS) supported employment to several SUD treatment provider agencies, first with SOR funding and now with SAPT BG Stimulus funds.



Delaware: The Community Well-Being Initiative (CWBI) was established in 2021. CWBI is a community-driven, place-based prevention strategy designed to promote community well-being and resiliency and break the cycle of death and co-morbidities associated with the use of opioids and other drugs, in Black and brown communities and individuals who may not seek formal services by providing connection to behavioral health treatment, recovery support services, and opioid related overdose prevention. The intent is to address the trauma and toxic stress that community members may have experienced and have been exacerbated by the impact of the opioid epidemic and COVID, through an initiative that is of, by, and for the community members it is intended to serve. Community Well-Being

Ambassadors (CWAs) provide support directly to community members. The support includes helping individuals and families identify their most pressing needs, providing relevant information, and developing strategies for addressing those needs, including connection to behavioral health and other community services and on-going support. CWAs have lived experience and reside within the target areas they serve. CWAs are trained utilizing SAMHSA endorsed strategies to increase access to prevention. Through peer modeling, CWAs are uniquely situated to connect community members to resources and bridge the gap of unmet needs between the community and substance use services. The CWAs conduct outreach throughout the target areas to promote meeting people where they are and providing support especially if individuals identify a need for harm reduction and/or recovery supports. CWAs provide education and complete referrals for individuals struggling with opioid and other substance use disorder (SUD) conditions and COVID-19 related impacts, which can include housing, employment, access to health care, and access to child care services. Ambassadors are also trained in Naloxone administration and they distribute Naloxone and critical knowledge of overdose prevention to the community.

As transportation remains a social determinant of health and known barrier to the State of Delaware for clients to access quality care and recovery support services, the Delaware Division of Substance Abuse and Mental Health (DSAMH) partnered with Ride Roundtrip Inc. in 2021, for non-emergency medical transportation service via their digital transportation marketplace. Through this partnership, DSAMH shall: Integrate with the Delaware Treatment and Referral Network (DTRN) for seamless access to services; and ensure all data stored is in a HIPAA compliant format; efficiently coordinate all levels of transport: Medical Sedans, Wheelchair Van, and Non-Emergency Ambulances (Basic life support, advance life support, special care transportation, bariatric ambulance); automatically send trip reminders via text or phone call to patients & maximize compliance with rides to reduce no shows; monitor rides with real-time GPS tracking; and provide the ability to review ride data including to/from addresses, ride time, ride cost, purpose of ride, driver information, and patient details; allow for easy access of financial and quality metrics in real-time for full transparency; and increase the utility of quality data from DTRN to inform rates and reimbursement policies towards non-medical emergency transportation.



Georgia: The state uses peers from Addiction Recovery Support Centers in the Emergency Department. The state's warmline is run by peers.



Idaho: Regular subgrantee calls provide the opportunity for the state to provide training and technical assistance, ensuring all receive the same message; the state has found that this meeting also serves as a platform for subgrantees to brainstorm and collaborate.



Illinois: Having Operational Definitions that are consistent and inclusive is critical across communication lines, proposal development, better understanding for grading proposals, foundational in making acceptable cost/services categories, and essential to formatting outcome and impact management. The state has utilized the assistance and partnership with Recovery Corp of America in a concerted effort to train and enhance the Recovery Support Services workforce. The state is currently

training and placing approximately 25 Recovery Navigators with different lead agency partners across the state each year.



Kentucky: The state has had success in expediting funding opportunities for RSS using Notices Of Funding Opportunities instead of Requests For Proposals. Additionally, they have had success in the use of Implementation specialists to coordinate RSS across various agencies funded through SOR. RCCs meet monthly in a Learning Collaborative. The state has incorporated use of data that highlights equity, racial disparities, MOUD, and types of RSS. In addition, the state has worked to reduce stigma of SUD with employers and has engaged Chambers of Commerce. Twelve staff are placed in comprehensive Career Centers to work on employment using the IPS model.

KYSTARS (Kentucky System Transformation – Advocating Recovery Supports) provides educational classes and technical assistance in implementation and developing policies and procedures, form development, grant writing and fundraising, program evaluation, and other issues, to the Consumer Operated Service Programs (COSP) across the state. Kentucky currently has COSPs in eight of the 14 Community Mental Health Center regions, with another one in development.

KYSTARS provides an annual fidelity review and technical assistance regarding outcome measures to all of the COSPs. Results of these reviews assist in shaping the educational opportunities made available at the annual KYSTARS statewide conference. An entire track at this conference is dedicated to individuals working in COSPs across the state.

KYSTARS has provided an annual statewide conference since State Fiscal Year 2011. The Annual Peer Excellence Awards, a ceremony that occurs the night before the actual conference, continued and regional peer excellence awards were awarded. This award ceremony recognizes an outstanding individual with lived experience from designated geographical regions across the state. It also recognizes supporters of peers and individuals with lived experience who have made significant contributions in the field of recovery. For the last six years KYSTARS has also recognized a youth peer specialist and a family peer specialist who have been nominated for their stellar performance in supporting recovery and resiliency.



Louisiana: The state is working towards the expansion of peer support services in higher education/secondary education programs, as well as expanding peer services in the Louisiana Crisis Response System. The state is partnering with the Board of Regents and various NAMI affiliates throughout the state to target colleges and universities with campus peers to provide additional supports to students experiencing substance use and/or mental health challenges. The state is also identifying crisis response providers through for each region of the state to ensure access to crisis services statewide.



Maine: The Office of Behavioral Health Recovery Manager has been meeting regularly with potential new RSS providers to detail service delivery expectations and assess and support capacity development and readiness. Additionally, via a Statewide Coordinating agreement, an RCO provides technical assistance and data collection support to several smaller RCOs providing RSS.



The Commonwealth of Northern Mariana Islands (CNMI): To add to traditional therapeutic practices, an innovative recovery measure for the CNMI Commonwealth Healthcare Organization's Community Guidance Center's RSS includes the incorporating of activities that embrace nature and the environment with a therapeutic approach and physical recovery. Such hobbies include that of hiking, ocean-related activities, golf, etc. Consumers show great interest in physical disciplines, and invest their time, skills, and knowledge in these areas of interest that promote physical health, behavioral health, and wellness.



Michigan: The state developed a Youth Peer Curriculum to serve adolescents age 15–17. In addition, they have implemented the Recovery Capital Assessment to help recovery residences and recovery service organizations build sustainable recovery in the population.



Missouri: The most effective strategy is to have a dedicated office on the leadership team within the SSA that is committed to recovery and works directly with the recovery community. Having leadership that knows the history about how things have developed over the years and fully integrated into the SSA is crucial. The second essential strategy is having a grassroots organization that represents the recovery community with a unified voice. The Missouri Coalition of Recovery Support Providers (MCRSP) is the statewide recovery organization. Their structure includes regional affiliates (Recovery Oriented Systems of Care) that bring the entire recovery community together in each ROSC on at least a monthly basis. Many issues are worked out at the local levels by having these collaborations. The state then brings all the ROSCs together under the MCRSP umbrella to deal with issues of statewide concern. Having these mechanisms in place and relationships established allows the state to work through most problems and to celebrate successes.

Lessons learned: 1) If you have a voucher system for RSS funding, do not allow the place issuing the voucher to also provide RSS services themselves (thus being able to issue vouchers for their own clients). The organization issuing the vouchers should be completely independent from any direct service providers. 2) Keep paperwork requirements on RSS providers to a minimum. Most RSS providers are very small and do not have the administrative staff to comply with all kinds of paperwork requirements. Many will forego public financing rather than engage with a system that distracts them from providing direct services. 3) Keep barriers low for clients seeking services. Having too many requirements on people seeking services (such as requiring an assessment, GPRA, etc.) can scare people away from seeking services. SSAs need to balance the need for accountability with the need to give RSS providers flexibility in reaching out to people who normally might not seek out services. 4) Seek broad input. There are a lot of people who have a lot of good ideas. Build channels for feedback into your system, such as the establishment of ROSCs and statewide RCOs. Empower these state and local organizations to take ownership over the delivery system within which they operate. People at the local level often know what is best for their communities and what services are needed.



New Hampshire: The state funds a state-wide Facilitating Organization that subcontracts with independent RCOs to develop their capacity and ensure they meet contract requirements and standards, oversee quality improvement, provide assistance with billing, provide training and TA, collect, report and assist with evaluation of data.



New Jersey: The state enables the ability to blend funds from multiple sources and stabilize funding for RSS by offering multi-year grants and providing confirmation of funds in advance of the start date of the grant and providing confirmation of funds in advance of the start date of the grants.



Ohio: Ohio has implemented peer recovery supports in the criminal justice system. In the last year, 86 incarcerated individuals successfully completed virtually the 40-hour PRS training. Peer services began offering continuing education opportunities to incarcerated individuals who completed the 40-hour PRS training. The state has provided Leadership and Professional Development training to incarcerated Peer supporters in developing the skills and confidence necessary to serve as positive leaders in the prison environment. Peer Services also offered two virtual Peer Support employment panels, giving incarcerated Peers the opportunity to learn from active community Peer Supporters. In FY 23, a team of specially trained PRS training facilitators with a lived experience of incarceration will begin offering in-person PRS Trainings to incarcerated individuals on an ongoing monthly basis. In Ohio the employment group has worked hard to establish an ongoing partnership with Ohio's state Vocational Rehabilitation, Opportunities for Ohioans with Disabilities (OOD). Through this partnership Ohio has established an elevated supported employment rate for agencies that have passed the IPS (Individual Placement Support) supported employment program fidelity process. This program is serving several individuals with serious mental health and/or substance use disorders throughout Ohio. The Ohio MHAS (Mental Health and Addiction Service) and OOD partnership has provided consistent reimbursement and support of an evidence based supported employment program that been shown to help individuals obtain and retain employment.



Oregon: Measure 110 helped to engage those with lived experience and is grounded in Equity. The Block Grant Steering Committee is being revamped to include more lived experience members and to be more community directed.



Puerto Rico: Puerto Rico has produced short-form videos facilitated by peer staff to be shared through social media about the work that is being done. This supports the visualization of work being done, and inspires other people in recovery to see what they are capable of achieving. The integrating of peer staff into on-going clinical trainings coordinated by an agency to provide a lived-experience perspective in the implementation of services has been effective.



Rhode Island: By creating a state system with multiple providers of the same type of service but in different geographic areas, the state was able to create a collaborative where providers succeeding in certain areas of peer services can mentor other providers on how they succeed, bringing up the quality of services statewide.



South Carolina: Several RCOs in the state have developed mobile presence in the surrounding counties of their main locations, to include pop-up/mobile RCOs to serve additional areas of need. Two of the state-funded RCOs have established working relationships with the school districts within their service area to introduce RSS to both middle and high school attendees.



Tennessee: Addiction Recovery Programs (ARP) are throughout the state and are specific to recovery support, providing an array of diverse services; Lifeline Program - Peers initiate self-help groups and help connect persons with treatment statewide; Treatment courts collaborate with faith-based community to support family activities with treatment court participants; CPRS providing support in prisons.



Washington: The state has had success in contracting with smaller and BIPOC organizations to help grow and support them in learning about state contracting and procurement processes. Increasing the recruitment of BIPOC peer counselors, peers integrated into mobile crisis teams across the lifespan, Washington State has focused on ensuring that people with lived experience are integrated into recovery support programs. The Washington State legislature has created significant investment in permanent supportive housing units for individuals enrolled in Foundational Community Supports through the Apple Health and Homes Act.



Washington DC: The Re-entry Workforce Development initiative aims to create an opportunity for success through employment for formerly incarcerated District residents with Opioid Use Disorder and Stimulant Use Disorder. In this re-entry program, career readiness training will be provided pre-release and post-release to provide the necessary support for a paid six-month workforce development program upon discharge from DOC or the Federal Bureau of Prisons. The program is comprehensive, and the participants will also receive reentry services and peer support.

12. Endnotes

1. This number is reflective of only the identified sources and does not include Medicaid, any other federal agencies or other sources outside those specified.
2. For individuals age 12 and older.
3. Reported spending reflects only RSS and no other components of the Substance Use Disorder continuum (prevention, early intervention, treatment), and therefore does not reflect a complete state spend on SUD.
4. National Council on Behavioral Health (2018). [SAMHSA Recovery Research and Evaluation Technical Expert Panel summary report](http://bit.ly/3V9tjA9). <http://bit.ly/3V9tjA9>
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6. White House Executive Office of the President Office of National Drug Control Policy (2022). [National drug control strategy](https://bit.ly/3ziHN8y) (p. 11). <https://bit.ly/3ziHN8y>
7. National Council on Behavioral Health (2018). [SAMHSA Recovery Research and Evaluation Technical Expert Panel summary report](http://bit.ly/3V9tjA9). <http://bit.ly/3V9tjA9>
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9. Service categories were: Recovery Community Centers, Recovery Housing, Peer Recovery Coaching, Workforce Development, Recovery Supports, and Other.
10. This number is reflective of only the identified sources and does include Medicaid, any other federal agencies or other sources outside those specified.
11. U.S. Substance Abuse and Mental Health Services Administration (2022, January 11). [2020 NSDUH detailed tables](https://bit.ly/3D9IJ04). <https://bit.ly/3D9IJ04>
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