

## **RESPONSE TO THE OPIOID CRISIS**

### ***The Problem***

Over the past two decades in the United States, the use of opioids – the group of drugs that includes heroin and prescription painkillers – has escalated dramatically, with enormous human and financial costs to individuals, families and communities.

The Hazelden Betty Ford Foundation sees the devastating effects of opioid addiction every day at its 16 locations, and our observations in recent years have been consistent with a wave of sobering statistics that reveal a public health crisis that the Centers for Disease Control and Prevention (CDC) calls the worst drug addiction epidemic in U.S. history.

For starters, the CDC reports that prescription painkiller overdoses more than quadrupled in the U.S. from 1999 to 2011, and heroin overdoses more than doubled, leading to about a half million emergency department visits in 2010 alone. While the newest reports show prescription drug misuse and deaths leveling off, heroin deaths are on the rise, and both remain at unacceptable levels. Deaths from drug overdose still outnumber those caused by car accidents, with an average of 110 overdose deaths per day in America and more than half of those involving opioids, according to the CDC.

Not surprisingly, opioid use disorders are also on the rise. Data compiled by the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2012 showed treatment systems nationwide reporting a 500 percent increase in admissions for prescription drug disorders since 2001. All told, the National Institute on Drug Abuse estimates 2.6 million Americans had an opioid addiction in 2012. Millions more, while not addicted, also reported nonmedical use of prescription painkillers, according to the CDC.

These alarming increases in overdose deaths, addiction and misuse parallel, as one might suspect, a skyrocketing rate of opioid prescriptions and use. The CDC says prescriptions for opioid painkillers, or analgesics, have tripled in the past two decades. In 2012, 259 million opioid prescriptions were written, enough for every American adult to have a bottle of pills. Today, despite having only 4.6 percent of the world's population, the U.S. consumes 80 percent of the world's supply of painkillers, according to the American Society of Interventional Pain Physicians.

These troubling trends began to emerge in the late 1990s, after the U.S. Food and Drug Administration (FDA) approved OxyContin and allowed it to be promoted to family doctors for treatment of common aches and pains. State medical boards loosened standards governing opioid prescribing and then, in 2000, the Joint Commission on Accreditation of Healthcare Organizations implemented new pain management standards. Soon, more physicians and organizations began advocating for increased use of opioids to address what at the time was perceived to be a widespread problem of undertreated pain.

When prescribed on a short-term basis to treat severe acute pain, opioids can be helpful indeed. In fact, they are one of the best medicines we have. But when these highly addictive medications are taken around-the-clock, for weeks, months and years to treat relatively common conditions, they may actually produce more harm than help. An increasing body of research suggests that for many chronic pain patients, opioids may be neither safe nor effective. Over time, patients often develop tolerance, leading them to require higher and higher doses, which ultimately can lead to quality-of-life issues and functional decline, not to mention addiction. In some cases, opioids can even make pain worse, a phenomenon called hyperalgesia.

Opioid prescription standards in the U.S. are so flexible now that patients sometimes get opioids even when they don't complain of pain. A 2014 study by the George Washington University School of Medicine showed a 10 percent increase in opioid prescriptions written for people visiting the emergency room, yet only a 4 percent increase in people coming to the ER complaining about pain.

Many people associate prescription painkillers with older adults, and that certainly is a significant population affected by the current crisis. Among those 65 or older, nonmedical use of prescription medications is the No. 1 drug of choice.

Youth are increasingly at risk too, especially with opioids available in the medicine cabinets of so many homes. Young people are particularly vulnerable because their brains aren't fully developed until the mid-20s. Teens think the drugs are safe because a doctor prescribed them. But opioids can cause permanent changes to the brain. When abused, painkillers can be as life-threatening as heroin.

As early as 2005, nearly one in five teens, grades 7 to 12, were reporting they had used prescription painkillers such as Vicodin or OxyContin to get high. According to the Foundation for a Drug-free World, 2,500 American youths abuse a prescription pain reliever for the first time every day. Furthermore, in the 2012 National Survey of American Attitudes on Substance Abuse, 34 percent of teenagers reported they could get prescription drugs within a day. The National Institute on Drug Abuse (NIDA) says 70% of 12th graders reported obtaining prescription narcotics from a friend or relative and that adolescent abuse of prescription drugs frequently is associated with other risky behavior.

According to Leonard Paulozzi, a physician and researcher with the CDC, about 75 percent of heroin users say they started out by using prescription opioids. That is consistent with what we hear from the 35 percent of our young patients who have an opioid use disorder. They often report a relatively swift path from medicine bottle to heroin needle. As prescription supplies dry up and doctor-shopping options run out, heroin becomes the cheaper and more available alternative. That progression is scary considering that teenage abuse of prescription drugs has become so prevalent the Partnership for a Drug-Free America refers to this age group as "Generation Rx."

Opioid problems are affecting every area of the country, devastating an entire generation in some hard hit communities like the New York City borough of Staten Island, where someone died of an opioid overdose every five days, on average, in 2012. Many of the lost are young people and parents. And many of those who escape death spend time incarcerated or are unfit to raise children because their addiction remains untreated. This is a crisis that demands our attention and commitment.

At the center of this problem is overprescribing. Doctors didn't start overprescribing opioids out of malicious intent but, rather out of a desire to treat pain more compassionately. The No. 1 reason people visit a physician is pain. Doctors were mistakenly informed beginning in the 1990s that treating pain with opioids was safe. Physician visits are shorter. Non-prescription related health support services for pain patients have been fragmented and underutilized. Pressure to make decisions and provide quick solutions add to the doctor's dilemma. Often it is easier for a physician to write a prescription to maintain the 'status quo' than to ask the difficult question, "Should I change how I am treating this patient?"

We have a culture that now seeks opioid medication for pain relief, perhaps a natural outgrowth of pleasure seeking within a significant percentage of patients who take opioids for pain. In the absence of more holistic self-care approaches, it makes sense that some patients are at significant risk for the development of addiction in our culture which promotes 'quick-fixes', instant gratification and escapism. We have learned that recovery from pain conditions, and recovery from pain and addiction requires far more than taking pills.

In addition, education campaigns, funded in many ways by opioid manufacturers, minimized risks, especially the risk of addiction, and exaggerated benefits of using opioids long-term for common problems. In fact, there is no substantial evidence to support the long-term use of opioids for chronic pain, and doctors need to become aware of the serious risk of overdose, dependence and addiction associated with opioid pain medications.

It's time for new education campaigns and new policies to help us recalibrate and find a better balance – one that addresses opioid overprescribing and overuse without stigmatizing pain, in whatever imperfect but thoughtful ways we can.

## *Our Clinical Approach*

### **Comprehensive Opioid Response with Twelve Steps (COR-12)**

In 2012, prior to the Hazelden and Betty Ford Center merger, Hazelden launched a new treatment protocol designed to address the grim reality that more people were becoming addicted to opioids and dying from overdose. Of particular concern was the risk that patients whose tolerance decreased during abstinence could relapse and easily overdose just by taking the same doses they used to take.

The new protocol – Comprehensive Opioid Response with 12 Steps or COR-12 – embraced the latest and best research that indicated certain medications could be used to improve recovery outcomes for people with opioid use disorders, and integrated those treatments into our world-class Twelve Step Facilitation model to form the foundation of a unique new approach.

The Hazelden Betty Ford Foundation's COR-12 team consists of medical, clinical and research professionals whose collective goal is to improve the lives of those suffering from opioid addiction. Our program encompasses the whole spectrum of recovery—from pre-recovery, to recovery initiation, to ongoing and lifelong recovery support services. The COR-12 treatment path includes group therapy and lectures that focus on opioid addiction as well as two extended medication assistance options - 1) use of buprenorphine/naloxone (Suboxone®) or 2) use of extended release naltrexone (Vivitrol®) – offered and provided under closely supervised care. Patients also can choose to participate in COR-12 without medication assistance.

"We use medications to engage our opioid dependent patients long enough to allow them to complete treatment and become established in solid Twelve Step recovery," said Chief Medical Officer Marvin Seppala, M.D. "Our goal will always be to discontinue the medications as our patients become established in long-term recovery."

### **Pain Management Program**

At the Betty Ford Center in Rancho Mirage, Calif., we are now offering a unique treatment program where patients can initiate their recovery from a substance use disorder while simultaneously addressing their chronic pain problems.

People who use opioids, alcohol and other drugs to cope with chronic pain develop a state of chronic stress. We help them relearn how to focus and how to de-stress. When the mind is relaxed -- and this is key to our treatment -- it will go to a place of healing.

This residential program is designed and directed by the internationally-recognized pain management expert Dr. Peter Przekop. Rather than dealing with the physical cause of pain, our pain management program is based on reshaping how the brain reacts to pain, utilizing non-opioid interventions.

We also have an outpatient program in Beaverton, Ore., which takes a long-term approach to the treatment of pain and addiction and is led by one of our nationally recognized opioid experts, Dr. Andrew Mendenhall.

### **Professionals in Residence Programs**

The Hazelden Betty Ford Foundation has Professionals in Residence (PIR) programs in Minnesota and California, offering doctors and other health care professionals the opportunity to learn how to recognize and assess substance use disorders, including opioid use disorders. These programs allow professionals to visit our facilities and participate in the treatment experience for a week while they are learning. The experiential model facilitates an in-depth, personal and unique learning experience that tends to “stick with” participants.

Our PIR staff also helps us host special events. In June 2014, for example, we hosted a special two-day conference in Minnesota called Addiction Medicine for the Primary Care Provider, and much of the discussion revolved around opioids. It was a model for how our PIR programs can help us address the nation’s opioid crisis.

### **Summer Institute for Medical Students**

Another leverage point for us in the fight against opioid overprescribing is our Summer Institute for Medical Students (SIMS), led by Joseph Skrajewski, Director of Medical Education Programs at the Betty Ford Center and a national leader in addiction education for doctors.

The SIMS program, like our PIR programs, gives students the opportunity to be part of the addiction treatment experience for a week. The main difference is that it targets medical students rather than those already working in the profession. Instead of sitting in a classroom, the students learn by integration into the daily life of either patients or family program participants at the Betty Ford Center. The idea is to help our nation’s future doctors understand the recovery process by letting them see it happen.

In the effort to educate doctors about the risks of overprescribing opioids and how to recognize and treat opioid addiction, the SIMS program can serve as a powerful model and resource.

### **Health Care Professionals Treatment Program**

In Minnesota and Oregon, we now have a specialty treatment track for health care professionals who become addicted to opioids and other drugs themselves. We help them recover from their addiction, salvage their careers and eventually re-enter the workforce as advocates for addiction prevention and recovery. Recovering health care professionals, whether they publicly disclose their recovery status or not, can be valuable allies in our effort to promote more cautious opioid prescribing practices, as well as other related priorities.

### **Age-Specific Treatment Programs**

We have developed a great deal of opioid expertise at our Naples, Fla., location, where we have a Boomers & Older Adults treatment track that helps our oldest clients, and in New York City and Plymouth, Minn., where we treat our youngest patients.

These programs allow us to learn more about how the opioid crisis is affecting these two distinct populations, helping greatly to inform our efforts at the Institute for Recovery Advocacy.

## *Our Public Policy Priorities*

As the nation's largest nonprofit provider of addiction prevention, treatment and recovery services, the Hazelden Betty Ford Foundation has an important responsibility, and is uniquely qualified, to comment on public policy opportunities that could help reduce the enormous impact of opioid misuse and addiction, which we see every day at our 16 locations across the United States. As such, we are pursuing the following advocacy priorities.

### 1) **EDUCATE & PREVENT**

- **Training for dentists, doctors and pharmacists.** We support the aggressive expansion of education and training for health care providers about the dangers of overprescribing opioids, the signs of addiction, and alternatives for addressing pain. We also urge medical schools to expand their curricula on substance use disorders.
- **Public education.** We support national education and prevention campaigns that target youth and their parents, older adults and the general population to dispel myths, provide facts and resources, and reduce stigma. One idea we support is educational literature for consumers, provided with their opioid prescriptions.
- **Promotion of non-medication pain management therapies.** We encourage public and private organizations to follow the lead of groups like Minnesota's Veterans Administration in embracing healthy approaches to pain management that do not rely so heavily on pain medications. We also urge state medical boards to include diverse pain management guidelines in their policies. Our own survey in October 2014 supports this priority, finding that 80 percent of respondents are willing to reduce or eliminate their current chronic pain medications and try alternatives instead.

### 2) **MONITOR**

- **Effective Prescription Drug Monitoring Programs (PDMP).** We support and encourage more efforts to strengthen state PDMPs, including mandated utilization, appropriate funding and coordination of PDMPs across state lines. Grants to state substance abuse agencies, including the Substance Abuse Prevention and Treatment Block Grant, could require coordination across state lines and mandatory PDMP utilization, for example. Utilization is especially key since studies show that in states where it is not mandatory, the PDMP is used only a third of the time.
- **Responsible medication approvals and labeling.** We urge the U.S. Food and Drug Administration (FDA) to refrain from approving new high dosage opioid painkillers, especially those easily crushed and therefore more prone to abuse and diversion, unless they are clearly safer than existing products. We also encourage medication labels that appropriately limit approved uses.

- **Effective law enforcement.** We support strong sentences for criminal overprescribing of opioids as well as enterprising diversion schemes intended to supply the illegal drug market.

### 3) **DISPOSE**

- **Disposal of unused, unneeded medications.** We support the U.S. Drug Enforcement Administration’s regulations governing the safe and secure disposal of prescription medications at authorized collection locations. We urge communities to vigorously promote their authorized collection locations with community-wide Prescription Drug Take-back Days and would like to see the DEA revive them as a means of continued public education about the dangers of keeping excess medications in the home or workplace.

### 4) **REVIVE**

- **Availability of overdose “rescue drugs.”** We encourage expanded access to the opioid antidote Naloxone, and we support “Good Samaritan” laws which encourage people without the antidote to call 911 for help when they witness an overdose without fear of being arrested themselves for drug possession or being under the influence. States such as New York have trained thousands of first responders and lay individuals to recognize and respond to opioid overdoses using Naloxone, and many have companion “Good Samaritan” laws. We encourage similar policy nationwide.

### 5) **TREAT**

- **Accessible evidence-based treatment for opioid dependence.**
  - i. **Longer-term care.** A new law in Massachusetts requires insurers to pay for up to 14 days of inpatient care for those in need of acute treatment for addiction and forbids insurers from requiring prior authorization. Research, as well as the experience of our COR-12 program, shows that engaging patients longer improves their chances for sustained recovery, and we agree with the thrust of the Massachusetts law. While we believe the level of care (i.e. residential, intensive outpatient, etc.) is best determined by clinicians using American Society of Addiction Medicine (ASAM) criteria, we support the emphasis on longer-term care.

- ii. **Safe, responsible use of medication assistance when appropriate.** We support the use of certain medications if used adjunctively with therapy and recovery support to minimize risks and maximize benefits. Our COR-12 program is a model. To that end, we encourage primary care doctors who prescribe medications for opioid addiction to prescribe therapy and recovery support resources as well. In addition, we encourage doctors to consider naltrexone or its extended-release version – Vivitrol – as a viable alternative to Suboxone in some cases, and to consider both of those options as the safest alternatives. To ensure thorough consultations are possible between primary care doctors and their patients with opioid addiction, we also urge that existing limits be maintained on the number of patients to whom a doctor can prescribe Suboxone.
- iii. **Abstinence as long-term goal.** We know from years of experience that abstinence is a realistic goal for people with opioid addiction, and we urge all professional caregivers to pursue that goal.
- **Criminal justice reform.** We strongly support the expansion of Drug Courts and similar corrections alternatives that are more rehabilitative than punitive and that have proven to reduce crime, save money, ensure compliance and restore families. We also believe legislative efforts like The Second Chance Act can help those who were convicted of drug offenses get back on their feet through treatment, re-entry programs and employment training. We further support efforts to reform draconian mandatory sentencing laws, restore the voting rights of recovering drug offenders and provide them with more and better sober housing options.

## 6) SUPPORT

- **Grants to recovery community organizations (RCOs).** We support grants and efforts to help establish RCOs throughout the country to help connect recovering people so they can support one another in the community context and be a magnet for others in their community who might seek recovery as well. While recovery often begins with treatment, it is sustained in the community, and people with opioid addiction benefit substantially from long-term recovery engagement. We specifically encourage efforts to establish or revitalize RCOs in Southern California and Oregon, where we are discharging large numbers of patients to communities that may not have vital RCOs.



- **Telehealth and other remote supports.** We urge federal and state legislation that would make it more feasible for organizations like ours to provide care remotely using telehealth technologies. The greatest challenges are obtaining provider licenses across multiple state lines and accessing insurance reimbursements for care delivered in this manner. This is relevant because patients on medication assistance for opioid addiction require continuing care services that support their long-term journey to abstinence, and it is difficult to engage them long term without doing so remotely. Telehealth technologies also could help bring therapy resources to locations where primary care doctors are able to prescribe Suboxone but unequipped to provide addiction counseling. That was a clear need expressed by participants at our 2014 Addiction Medicine for the Primary Care Provider Conference. American Indians, military veterans, and residents of rural areas, for example, would benefit greatly from greater access to care.
- **More sober housing and recovery schools.** A key component of treating people with opioid addiction is ensuring stability through the lengthy recovery process. More and better sober housing options would help provide that stability, as would recovery high schools and collegiate recovery programs, all of which we support expanding.



## **Hazelden Betty Ford Institute for Recovery Advocacy Supports Recovery Legislation**

The Hazelden Betty Ford Institute for Recovery Advocacy strongly supports passage of the [Comprehensive Addiction and Recovery Act](#), federal legislation that will help address the nation's opioid epidemic.

Over the past two decades in the United States, the use of opioids – the group of drugs that includes heroin and prescription painkillers – has escalated dramatically, with enormous human and financial costs to individuals, families and communities.

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The bipartisan legislation was introduced in both the U.S. Senate and House as S. 524 and H.R. 953. It would make up to \$80 million available to states and local governments to expand drug treatment, prevention and recovery efforts. Among the provisions are grants to:

- Broaden access to evidence-based opioid treatments, and expand treatment best practices throughout the country.
- Create pilot programs to prevent opioid overdose deaths by providing training to law enforcement and other first responders on the use of Naloxone, an antidote for someone overdosing on heroin or prescription pain pills.
- Establish national education efforts to prevent substance abuse, promote understanding of addiction as a chronic disease, and bolster treatment and recovery. These efforts would be focused on parents and caretakers, teenagers, college-age individuals, adults and older adults.
- Expand high school and college recovery programs.
- Expand community-based recovery services.
- Expand disposal sites for unwanted prescription medications.
- Provide alternatives to incarceration for military veterans, including treatment courts and peer-to-peer services.
- Strengthen state Prescription Drug Monitoring Programs (PDMPs) to prevent overprescribing and diversion.

- Promote services for pregnant and parenting women in the criminal justice system who use opioids and other drugs.

The Hazelden Betty Ford Institute for Recovery Advocacy looks forward to providing input on the bill as it progresses through the legislative process and urges its stakeholders to contact their U.S. Senators and House Members to express support for the legislation.

“The opioid epidemic demands the attention of policymakers,” said Nick Motu, Vice President and head of the Hazelden Betty Ford Institute for Recovery Advocacy, “and we are grateful for the Senate and House leaders who are spearheading this important legislation.”

Motu pointed out that, according to the Centers for Disease Control and Prevention, prescription painkiller overdoses more than quadrupled in the U.S. from 1999 to 2011, and heroin overdoses more than doubled, leading to about a half million emergency department visits in 2010 alone. While the newest CDC data shows prescription drug deaths dipping slightly in 2012, heroin deaths shot up even more. And deaths from drug overdose still outnumber those caused by car accidents, with an average of 110 overdose deaths per day in America and more than half of those involving opioids, according to the CDC.

Not surprisingly, opioid use disorders are also on the rise. Data compiled by the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2012 showed treatment systems nationwide reporting a 500 percent increase in admissions for prescription drug disorders since 2001. All told, the National Institute on Drug Abuse estimates 2.6 million Americans had an opioid addiction in 2012. Millions more, while not addicted, also reported nonmedical use of prescription painkillers, according to the CDC.

These alarming increases in overdose deaths, addiction and misuse parallel, as one might suspect, a skyrocketing rate of opioid prescriptions and use. The CDC says prescriptions for opioid painkillers, or analgesics, have tripled in the past two decades. In 2012, 259 million opioid prescriptions were written, enough for every American adult to have a bottle of pills. Today, despite having only 4.6 percent of the world’s population, the U.S. consumes 80 percent of the world’s supply of painkillers, according to the American Society of Interventional Pain Physicians.



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## CYAHD's areas of interest are aligned with key national priorities

Local, state, and federal agencies all have a stake in understanding the health and well-being of young adults. While much attention has been focused on ways to improve the delivery of public education in the US, CYAHD is committed to understanding what health and psychosocial problems might interfere with the ability of young people to fully avail themselves of the learning opportunities available to them, and then translate the skills they acquired in secondary school and college into successful careers and other adult roles. There is a strong desire to identify what earlier factors during adolescence predict health, safety, and well-being during young adulthood. To that end, CYAHD conducts research on health risk behaviors and mental health issues that can interfere with successful development and translates this research to guide the development of intervention strategies.

## The Center began as an outgrowth of one of the largest NIH-funded longitudinal studies of young adults, the College Life Study (CLS), which began in 2003

The College Life Study (CLS) is an ongoing research study at the University of Maryland College Park. It began in 2003 and has been supported through grants from the National Institutes of Health. The study involves the annual assessment of a longitudinal cohort of 1,253 college students who were enrolled as first-time, first-year students at a large public mid-Atlantic university in the fall of 2004 via personal in-depth interviews. The CLS collects data on a wide array of individual and behavioral factors, including but not limited to alcohol, tobacco, illicit and nonmedical prescription drug use; physical and mental health conditions and utilization of services; academic performance and college experiences; academic and career goals; family and peer influences; perceptions and attitudes; and background characteristics, including demographics and high school experiences. Participants are assessed regardless of continued college attendance, thereby allowing for the opportunity to fully characterize the life trajectories of young people entering college.

This study is unique among the longitudinal studies at NIH because of its specific focus on college students, and on how college experiences impact post-college health, employment, and social functioning. Although many longitudinal studies struggle with high attrition, year-to-year retention of participants in the CLS has been excellent. After ten years, thanks to state-of-the-art recruitment strategies, almost 80% of participants are still active. The CLS has attained the status of a landmark interdisciplinary study, the results of which have had national and international prominence.

## Current Projects

- Drug Abuse Trajectories in the Transition to Adulthood: Risk Factors and Outcomes (The College Life Study)
- Maryland Statewide Collaborative to Reduce College Drinking and Related Problems
- Energy Drink Consumption Patterns and Longitudinal Relationships to ATOD Use
- Evaluation of the Alberta Adolescent Recovery Centre (AARC)
- Enhancing SBIRT with Parental Involvement: Evaluating the Process and Impact on Families
- Gambling and Substance Use among College Students
- Drug Use Trajectories and the Transition to Adulthood among Maltreated Youth

Download publications, fact sheets, and other information: [www.cyahd.umd.edu](http://www.cyahd.umd.edu)

### Contact Information

Amelia M. Arria, Ph.D.

Director and Associate Professor, Department of Behavioral and Community Health

2387 School of Public Health Building, College Park, MD 20742

Phone: 301-405-9795 Email: [aarria@umd.edu](mailto:aarria@umd.edu)

## **Collegiate Recovery Communities Programs: What Do We Know and What Do We Need to Know?**

ALEXANDRE LAUDET, PhD

*Director, Center for the Study of Addictions and Recovery, National Development  
and Research Institutes, Inc., New York, New York, USA*

KITTY HARRIS, PhD

*Professor, Department of Community, Family and Addiction Services,  
Texas Tech University, Lubbock, Texas, USA*

THOMAS KIMBALL, PhD

*Adjunct Associate Professor, Marriage and Family Therapy, and Associate Director,  
Research & Organizational Interventions Employee Assistance Program, Department of  
Neuropsychiatry, Health Science Center, Texas Tech University, Lubbock, Texas, USA*

KEN C. WINTERS, PhD

*Director, Center for Adolescent Substance Abuse Research, and Associate Professor,  
Department of Psychiatry, University of Minnesota, Minneapolis, Minnesota, USA*

D. PAUL MOBERG, PhD

*Research Professor, Department of Population Health Sciences,  
University of Wisconsin, Madison, Wisconsin, USA*

*As the broad construct of recovery increasingly guides addiction services and policy, federal agencies have called for the expansion of peer-driven recovery support services. The high prevalence of substance use and abuse in colleges and universities in the United States constitutes a significant obstacle to pursuing an education for the unknown number of youths who have attained remission from substance use dependence. Collegiate recovery programs (CRPs) are an innovative and growing model of peer-driven recovery support delivered on college campuses. Although no systematic research has examined CRPs, available site-level records suggest*

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Address correspondence to Alexandre Laudet, National Development and Research Institutes, Inc., 71 West 23rd Street, 4th Floor, New York, NY 10010, USA. E-mail: alexandrelaudet@gmail.com

*encouraging outcomes: low relapse rates and above-average academic achievement. The number of CRPs nationwide is growing, but there is a noticeable lack of data on the model, its students, and their outcomes. We review the literature supporting the need for the expansion of CRPs, present information on the diversity of CRP services, and outline key areas where research is needed.*

**KEYWORDS** *addiction, college students, recovery, recovery support services, substance use disorder*

As science is increasingly supporting the conceptualization of substance use disorders (SUDs) as chronic conditions (Dennis, Scott, Funk, & Foss, 2005; McLellan, Lewis, O'Brien, & Kleber, 2000), the SUD field is gradually moving from the prevalent acute care service model to a continuum care paradigm on par with that used for other chronic conditions such as diabetes or asthma. Although chronic conditions cannot be cured, the symptoms can be arrested and the condition managed using a mix of professional and peer-driven services and supports supplemented with self-management, based on the individual's needs, resources, and recovery stage. The widely used symptom management approach is effective in improving long-term outcomes for a range of chronic conditions, including asthma, cancer, diabetes, depression, and severe mental illness (Bodenheimer, Wagner, & Grumbach, 2002a, 2002b; Huber, 2005; Institute of Medicine, 2001; McLellan, McKay, Forman, Cacciola, & Kemp, 2005; Weisner & McLellan, 2004). In the addiction field, recovery support services (RSS) are a key component of the SUD continuum of care (Kaplan, 2008; Sheedy & Whitter, 2009; White, 2008, 2009). RSS can be delivered by professionals or by peers. Professionally delivered RSS include intensive outpatient or residential treatment, typically followed by continuing care or aftercare—a stepped-down course of services—a model that is heavily practiced and researched (McKay, 2001, 2009; McKay et al., 2009; McKay, Lynch, Shepard, & Pettinati, 2005). Also used are regular recovery management check-ups (RMCs) and early reintervention to monitor clients' status, minimize relapse risk, and provide linkage to services after relapse to shorten the cycle (Scott, Dennis, & Foss, 2005; Scott, White, & Dennis, 2007).

The most innovative form of RSS is the growing menu of peer-based RSSs. The President's National Drug Strategy, a document issued yearly through the White House Office of National Drug Control Policy (ONDCP), emphasizes the importance of promoting recovery, regardless of pathway; that is, whether or not professional treatment is sought (ONDCP, 2011). The Strategy calls for the expansion of peer RSSs across community-based settings and explicitly notes the importance of fostering the development of recovery supports in academic settings, a goal that it shares with the U.S. Department of Education as detailed in a recent monograph (Dickard,



Downs, & Cavanaugh, 2011). This article focuses on an innovative and growing model of campus-based RSSs, the Collegiate Recovery Program (CRP). We summarize research that supports the need for such programs, present available information on CRPs, and conclude with areas where key research is needed to further the dissemination of CRPs, including a brief description of a recently National Institutes of Health funded research project.

## HIGH PREVALENCE OF SUBSTANCE USE AND SUBSTANCE USE DISORDERS IN YOUNG PEOPLE

Drug and alcohol use, abuse and dependence among young people remain high. Young adults (age 18–25) have higher rates of illicit drug use and SUDs than other age groups (Substance Abuse and Mental Health Services Administration, Office of Applied Studies [SAMHSA OAS], 2008b). Importantly, SUD rates triple from 7% in adolescence (12–17) to 20% in young adulthood (18–25); alcohol use disorders (AUDs) alone triple from 5.4% to 17.2% during that transitional stage (SAMHSA OAS, 2008a; SAMHSA, Office of Communications, 2009). In 2007, 21.1% of young adults, or 6.9 million persons, were classified as needing treatment for drug or alcohol problems (SAMHSA OAS, 2009a). Although fewer than 10% receive needed treatment, the numbers are considerable: 24% of the 1,817,557 admissions to U.S. public SUD treatment in 2007 were 15 to 24 years old; 86.7% of these youth admissions were for drug problems (especially marijuana, hallucinogens, and inhalants) alone or drugs and alcohol (SAMHSA OAS, 2009a, 2009b). These numbers exclude those getting treatment privately and in non-specialty settings (McGovern, Saunders, & Vakili, 2011); moreover, most who remit from SUD are believed to do so without help (Granfield & Cloud, 2001; National Institute on Alcohol Abuse and Alcoholism, 2009; Toneatto, Sobell, Sobell, & Rubel, 1999). Thus the number of youths with a former but not current SUD (i.e., “in recovery”) is likely much higher than public treatment admission data suggest.

## RELAPSE RATES AND RELAPSE RISKS AMONG YOUTHS

Rigorous studies have identified a range of effective interventions for young people (Becker & Curry, 2008; Chung et al., 2003; Dennis et al., 2004; Hser et al., 2001; Kaminer & Godley, 2010; Waldron & Turner, 2008; Winters, Botzet, Fahnhorst, & Koskey, 2009; Winters, Stinchfield, Lee, & Latimer, 2008). However, as with adults (Anglin, Hser, & Grella, 1997; Laudet, Stanick, & Sands, 2007), posttreatment relapse rates are high and many youths are treated multiple times (SAMHSA OAS, 2008a). First-year posttreatment relapse rates range from 60% to 79% (Brown, Tapert, Tate, & Abrantes, 2000;



Brown, Vik, & Creamer, 1989; Chung, Maisto, Cornelius, & Martin, 2004; Chung, Maisto, Cornelius, Martin, & Jackson, 2005; M. D. Godley, Godley, Dennis, Funk, & Passetti, 2002); within 5 years, over 90% of treated youths return to substance use (Brown & Ramo, 2006; Chung et al., 2003; Winters, Stinchfield, Latimer, & Lee, 2007).

Stress, negative affect (e.g., depression), social situations, temptations to use (e.g., exposure to and availability of substances), and academic challenges, all highly prevalent in youths' daily context, constitute key relapse "triggers" for that age group (Baker & Harris, 2010; Brown et al., 2008; Cleveland & Harris, 2010; Gonzales, Anglin, Beattie, Ong, & Glik, 2012; Jaffe, 2002; Ramo, Anderson, Tate, & Brown, 2005; Svensson, 2000; Winters et al., 2008). The substance use status of peers is especially influential, predicting youths' substance use behavior (Cimini et al., 2009; M. D. Godley & Godley, 2011b; SAMHSA OAS, 2009a; White, 2008) and help seeking (Caldeira et al., 2009).

College attendance is increasingly important to professional and financial success. Transitioning into adulthood and into college are both demanding, offering new freedoms, opportunities, and responsibilities, with less structure and supervision (Wechsler & Nelson, 2008). For youths in SUD recovery, these normative challenges are compounded by the need to maintain sobriety (and academic performance) in an "abstinence-hostile environment" (Cleveland, Harris, & Wiebe, 2010; Wechsler, Davenport, Dowdall, Moeykens, & Castillo, 1994). The high prevalence of drug and alcohol use on college and university campuses (Hingson, Zha, & Weitzman, 2009; Knight et al., 2002; Wechsler & Nelson, 2008) makes college attendance a severe threat to sobriety (U.S. Department of Education, Higher Education Center for Alcohol and Other Drug Abuse and Violence Prevention, 2010; Woodford, 2001) that must often be faced without one's established support network if living away from home (Bell et al., 2009). This can lead to isolation when "fitting in" is critical, or to yielding to peer pressure to use alcohol or drugs, both enhancing relapse risks (Harris, Baker, Kimball, & Shumway, 2008; Woodford, 2001).

## NEED FOR RECOVERY SUPPORT FOR COLLEGE STUDENTS

Posttreatment continuing support is essential to and effective at maintaining SUD treatment gains (Dennis & Scott, 2007; S. H. Godley, Dennis, Godley, & Funk, 2004; S. H. Godley et al., 2010; Institute of Medicine, 2005; McKay, 2009; SAMHSA, Office of Communications, 2009; Weisner, Matzger, & Kaskutas, 2002; White, 2008). A menu of professionally and peer-delivered (e.g., recovery coaching) recovery management strategies exists for adults (Kaplan, 2008; McKay et al., 2009; Scott et al., 2005; White, 2009); combined, they constitute an emerging continuum of care consistent with chronic

disease management. Less attention has been paid to understanding the need for a developmentally appropriate recovery support system for SUD adolescents and transition age youths than to their adult counterparts (Hser & Anglin, 2011). Research has shown that an acute clinical care model alone is insufficient to sustain youths' treatment gains and achieve long-term recovery (SAMHSA OAS, 2009a, 2009b). Although there are promising youth aftercare strategies (M. D. Godley & Godley, 2011a; S. H. Godley et al., 2010), most young people do not access these resources (SAMHSA, Office of Communications, 2009). Only about a third receive professional aftercare (M. D. Godley, Godley, Dennis, Funk, & Passetti, 2007; McKay, 2001), and peer-based approaches (e.g., 12-step groups), although effective for youths, have a high attrition rate. Often, the older age composition of meetings limits the potential for identifying with other members that is critical to 12-step recovery (Chi, Kaskutas, Sterling, Campbell, & Weisner, 2009; Kelly, Brown, Abrantes, Kahler, & Myers, 2008). Researchers have called for life stage and context-sensitive strategies that can significantly impact youths' recovery rates and help them establish healthy lifestyles (Spear & Skala, 1995; SAMHSA, Office of Communications, 2009). A social environment supportive of recovery that fosters social connectedness is essential to youths sustaining a drug-free lifestyle. Central to the youth-specific context are school and peers: Staying in school, functioning effectively at school, engaging in non-drug-related leisure activities, establishing friendships with non-drug-using peers including peers in recovery, and having effective coping strategies to deal with exposure to peers' substance use are therefore recommended elements of an effective continuum of care for youths (Spear & Skala, 1995). Currently, in spite of high SUD rates and of the high prevalence of relapse triggers in youths' social context, we lack a comprehensive continuum of care system for youths (Spear & Skala, 1995; SAMHSA, Office of Communications, 2009).

Although experts have long noted the lack of campus-based services for recovering students and called for research on this population (Dickard et al., 2011; Doyle, 1999), few have heeded the call (Bell et al., 2009; Botzet, Winters, & Fahnhorst, 2008; Cleveland, Harris, Baker, Herbert, & Dean, 2007). Recovering SUD students are a "hidden group" to both researchers and college personnel (Woodford, 2001). Universities' efforts to address substance use understandably focus on prevention, screening, and treatment (Cimini et al., 2009; DeJong, Larimer, & Wood, 2009; Nelson, Toomey, Lenk, Erickson, & Winters, 2010; Saltz, Welker, Paschall, Feeney, & Fabiano, 2009; Winters et al., 2011). The U.S. Department of Education recently noted that "while academic institutions have been at the forefront of preventing substance use, the education system's role as part of the recovery and relapse prevention support system is still emerging" (Dickard et al., 2011, p. 10). Campus-based relapse prevention resources are typically scant, consisting of 12-step meetings and an unknown number of institutions offering "sober

dorms” (Finn, 1997; Join Together Staff, 2005; Laitman & Lederman, 2008), the usefulness of which is not known. Other needed services—campus-based supportive recovery community, relapse prevention and coping skills to negotiate high-risk interactions with substance-using peers, skills training (e.g., time management), counseling, sober social activities, supportive staff, academic and financial support—are generally either nonexistent or outsourced off campus, which is costly and interferes with classes (Dickard et al., 2011; Misch, 2009). Federal agencies have called for the expansion of community-based recovery support models to extend the continuum of care, including in schools and colleges (ONDCP, 2010; U.S. Department of Education, Higher Education Center for Alcohol and Other Drug Abuse and Violence Prevention, 2010). The developmental stage of SUD youths and the unique challenges of college suggest the need for appropriate infrastructure on campus to support students committed to recovery (Botzet et al., 2008; Misch, 2009). This infrastructure is the core of an innovative campus-based relapse prevention approach, the Collegiate Recovery Program, described in the following sections.

### COLLEGIATE RECOVERY PROGRAMS: AN INNOVATIVE CAMPUS-BASED RECOVERY SUPPORT MODEL

In the mid-1980s, a handful of universities started recognizing the need to provide support to college students in recovery from drug and alcohol use disorders as part of their broader effort to address substance use on college campus. These campus-based CRPs generally offered drug- and alcohol-free housing, onsite recovery support meetings (e.g., Alcoholics Anonymous and Narcotics Anonymous), and counseling provided by a small core staff (Botzet et al., 2008; Cleveland et al., 2010; Harris et al., 2008; Laitman & Lederman, 2008; Smock, Baker, Harris, & D’Sauza, 2011; U.S. Department of Education, Higher Education Center for Alcohol and Other Drug Abuse and Violence Prevention, 2010; White, 2001; White & Finch, 2006). The goal of CRP is to allow recovering students to extend their participation in a continuing care program without having to postpone or surrender achieving their educational goals. Thus CRPs strive to create a campus-based “recovery-friendly” space and supportive social community to enhance educational opportunities while supporting students’ continued recovery and emotional growth (Harris et al., 2008; White, 2001). As described in a handful of reports, these programs fit the paradigm of continuing care within a “recovery management” system that experts recommend (M. D. Godley et al., 2002). The model is also consistent with calls for appropriate campus-based infrastructure to support recovering students (Misch, 2009), with recent shifts in drug policy (ONDCP, 2010), and with the U.S. Department of Education’s goal of ensuring a continuum of care from high school to college to postgraduation (Dickard et al., 2011).

Through the 1990s, CRPs remained small programs, attracting little attention from educators, researchers, or federal agencies. About a decade ago, as substance use among youths and in particular, on college campuses, became increasingly recognized as a major public health concern by academic institutions and federal agencies, colleges and universities became interested in the CRP model. At about the same time, as SUDs were being conceptualized as chronic conditions for many (McLellan et al., 2000), the need for a continuum of care was increasingly noted (McKay, 2001) and SAMHSA began promoting a recovery-oriented, “chronic care” approach to SUD services (Clark, 2008). In 2005, SAMHSA and the U.S. Department of Education provided funding to Texas Tech University (TTU), one of the pioneer institutions with a CRP since 1986 (currently led by the second author), to provide technical assistance to universities interested in starting CRPs (Harris, Baker, & Thompson, 2005). In 2011, the ONDCP included its goal of building on that federal investment “to develop and disseminate information on a model collegiate recovery community curriculum” in partnership with the U.S. Department of Education in the President’s Drug Strategy (ONDCP, 2011, p. 40). These factors combined have fueled a rapid growth in CRPs from four programs in 2000 to 33 in 19 states today, serving an estimated 600 students currently (Table 1). Thus the number of CRPs has grown more than eightfold in the past decade. Moreover, many CRPs report that the annual number of student applicants exceeds capacity, further testifying to the need for such programs (e.g., Texas Tech, serving 65 students per semester, receives in excess of 25 additional qualified applicants annually who are declined because of capacity limit).

## WHAT WE KNOW ABOUT COLLEGIATE RECOVERY PROGRAMS

The rapid development of CRPs, although highlighting the need for these services, is occurring without a formal model or a solid empirical basis to guide service planning because we currently lack knowledge about college students in recovery. Individual CRPs are developed independently of one another, typically at the initiative of interested faculty or a small group of recovering students. As a result, while sharing the goals of providing a campus-based supportive recovery community, preventing relapse, and promoting academic performance, individual CRPs likely vary greatly on key dimensions that might influence student outcomes, such as structure, range and comprehensiveness of services, and entry and participation requirements (Bell et al., 2009; White & Finch, 2006).

Published reports are available about the CRPs at Rutgers, Texas Tech, and Augsburg College, established independently in 1983, 1986, and 1995, respectively (Botzet et al., 2008; Harris et al., 2008; Laitman & Lederman, 2008). Common across sites are a campus-based location, drug-free housing

**TABLE 1** List of Collegiate Recovery Programs

Institution Name	State	Year Started	Current Student Enrollment
Rutgers University	NJ	1983	21
Texas Tech University	TX	1986	65
Loyola	IL	1990	5
Augsburg College	MN	1995	91
University of Massachusetts	MA	2004	13
Tulsa Community College	OK	2005	30
University of Virginia, Charlottesville	VA	2006	8
Kennesaw State University	GA	2007	50
University of Texas, Austin	TX	2004	20
Georgia Southern University	GA	2008	30
The College of St. Scholastica, Duluth	MN	2008	9
James Madison University	VA	2009	5
William Patterson University	NJ	2009	16
Baylor University	TX	2010	4
Greenfield Community College	MA	2010	8
Ohio University	OH	2010	3
Southern Oregon University	OR	2010	15
University of Michigan, Ann Arbor	MI	2010	15
University of Mississippi	MS	2010	6
University of Vermont, Burlington	VT	2010	12
Vanderbilt University	TN	2010	27
University of California, Riverside	CA	2011	6
St. Cloud State University	MN	2011	9
Penn State University	PA	2011	18
University of North Carolina, Charlotte	NC	2011	9
University of Southern Mississippi	MS	2011	19
Wayne State University	MI	2012	6
Auburn University	AL	2012	10
Midland College	TX	2012	20
University of Alabama	AL	2012	20
University of California, Santa Barbara	CA	2012	5
University of Nevada, Reno	NV	2012	15
University of Oklahoma	OK	2012	10
Total students			600

options, individual or group counseling to discuss recovery and academic issues, relapse prevention “life skills,” and sober leisure activities; peer support and 12-step tenets are typically emphasized. Each site operates with a core small professional staff of two to six. Significant differences are also noted among these three CRPs in terms of entry requirements—for example, whether treatment history is required, minimum duration of abstinence ranging from 3 to 12 months (although how abstinence is verified is not specified); participation requirements (e.g., whether residing in sober housing is required, use of signed behavioral or sobriety contract); level of supervision (e.g., whether urine samples are collected when substance use is suspected), cost to students (two CRPs charge students, one is free)

and comprehensiveness of services (e.g., weekly seminars on addiction, availability of CRP-specific peer tutoring and academic advising).

Outcome reports are scant as well and limited to historical records at TTU and Augsburg; they bear on two domains:

1. Academics: TTU CRP students' average grade-point average (GPA; 3.18) is consistently higher than the overall TTU undergraduate GPA (2.93; Harris et al., 2008); the Augsburg CRP reports only a mean GPA of 3.2 between 1997 and 2010 (Augsburg College, 2014). TTU also publishes its CRP graduation rate (70%) that exceeds both TTU's 60% average (Texas Tech University Institutional Research and Information Management, 2010) and the national average of 55.9% (National Center for Higher Education Management System, 2010).
2. Relapse rates: Since 2002, the TTU CRP relapse rates (defined as "any use") per semester range from 4.4% to 8% ( $M = 6\%$ ; Cleveland et al., 2007; Harris et al., 2008). Augsburg's mean relapse rate from 1997 to 2010 is somewhat higher (13%). These rates represent the total number of relapsed students in a given semester, divided by the number of students served that semester. Each relapse episode is counted (Harris et al., 2008). Unlike GPA and graduation rates that universities document in details, there is no comparable relapse rate available for recovering students not enrolled in CRPs; moreover, because CRP students average 2 years of abstinence (Cleveland et al., 2007), their outcomes cannot be compared with treatment or to aftercare evaluation outcomes because such studies typically report only past 30- or 90-day outcomes (S. H. Godley et al., 2010). As an estimate, we might compare CRP relapse rates to rates reported in a prospective study of community-based adults in abstinent recovery from drug dependence and not enrolled in treatment ( $M$  age = 43,  $N = 354$ ; Laudet & White, 2008). At study intake, the mean duration of abstinence was 31.6 days. At 1-year follow-up, 34% of the sample had returned to drug use. Specifically, 57% of those who were drug abstinent under 6 months at intake, 41.5% of those who were drug abstinent 6 to 18 months at intake, and 15.9% of those abstinent 18 to 36 months at intake had returned to drug use at 1-year follow-up. Although not directly comparable, these rates suggest that reported CRP relapse outcomes are sufficiently encouraging to warrant a systematic evaluation of the approach.

## WHAT WE NEED TO KNOW ABOUT COLLEGIATE RECOVERY PROGRAMS

Numerous institutions interested in developing a CRP cite the lack of a formal model and systematic evaluation data as obstacles to gaining internal



institutional support to start a CRP, even though they recognize the need. The need to systematically evaluate CRPs is also noted in a report issued by the U.S. Department of Education in May 2011, with the goal of ensuring a continuum of care from high school to college to postgraduation. The report calls for prospective studies on substance use and academic outcomes among students in CRPs to inform the higher education system's response to college students in recovery (Dickard et al., 2011). The authors of this article recently received funding from the National Institutes of Health (NIH) to conduct an exploratory study of CRPs and their students as a first step in planning a systematic, rigorous evaluation of CRPs. The study will survey all existing programs and their students nationwide. At the program level, we will document the diversity of structure, range and comprehensiveness of services of the existing CRPs, and entry and participation requirements. At the student level, we will collect detailed information about students' addiction history and severity, paths and strategies to initiating recovery (e.g., treatment, recovery school, wilderness program, juvenile justice), to sustaining recovery until college (services utilization), and why they enrolled in a CRP. We will also examine college-specific recovery challenges and service needs, and be able to start characterizing an untapped subpopulation: SUD youths who sustain recovery, establish a drug-free life, complete high school, and go on to college. Although this group might be the exception rather than the norm, information about their recovery paths and the resources and strategies they used to sustain remission can be highly useful to continuing services development.

## CONCLUSION

The need for recovery support among college students with a former SUD is gradually being recognized and addressed by an innovative campus-based model that has been rapidly embraced yet remains to be systematically documented and evaluated. A small NIH study is underway to describe both program structures and students' characteristics and needs in preparation for a much needed large-scale evaluation. It is our hope that this article will increase awareness of the recovery support needs of college students, encourage academic institutions to develop programs to meet these needs, and prompt researchers to examine their outcomes.

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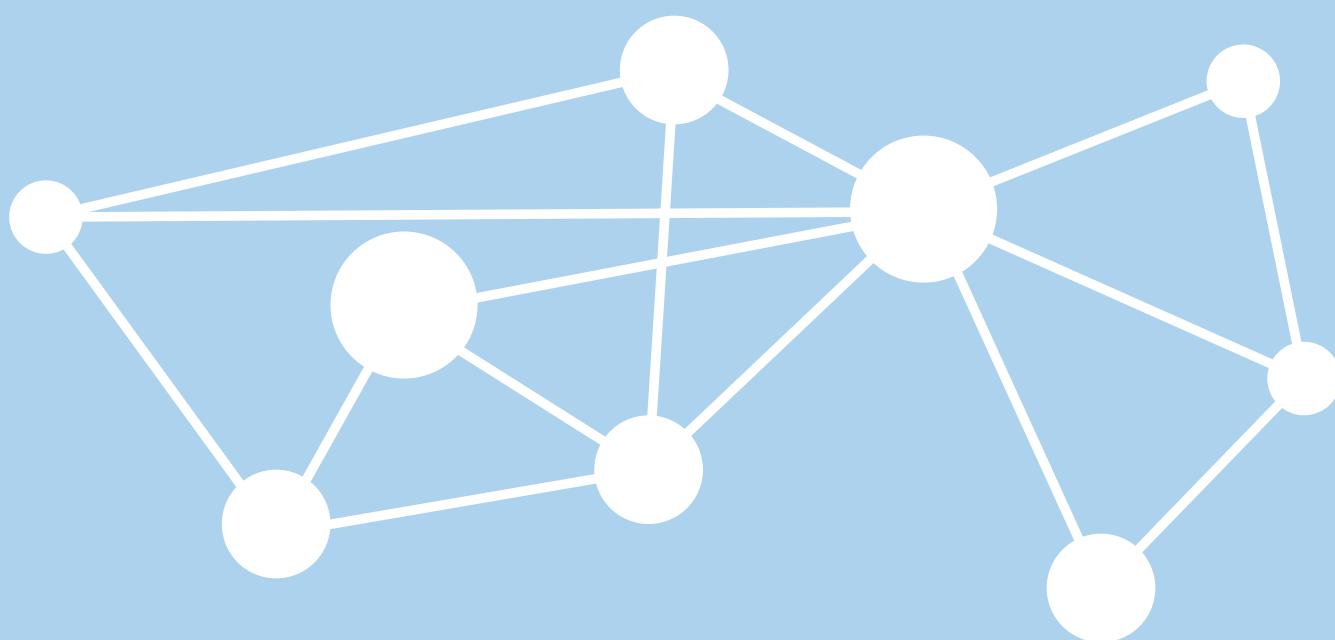
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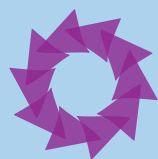
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# The 38 Assets for Building Collegiate Recovery Capacity



2014 Survey Report



Transforming Youth Recovery



For inquiries, please contact the Transforming Youth Recovery team:

**Ivana Grahovac**  
Executive Director  
(858) 350-1111  
[ivana@tyrecovery.org](mailto:ivana@tyrecovery.org)

**Jenna Parisi**  
Director of Collegiate Program Development  
(858) 350-1111  
[jenna@tyrecovery.org](mailto:jenna@tyrecovery.org)

**Cristina Hunter**  
Collegiate Program Manager  
(858) 350-1111  
[cristina@tyrecovery.org](mailto:cristina@tyrecovery.org)

**Transforming Youth Recovery**  
c/o The Stacie Mathewson Foundation  
P.O. Box 6448  
Reno, Nevada 89513  
<http://transformingyouthrecovery.org>




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# TABLE OF CONTENTS

<b>About Transforming Youth Recovery</b> .....	2
<b>Building Capacity for Collegiate Recovery Programs and Efforts</b> .....	3
Collegiate Recovery Programs Operating or Launching in the U.S. ( <i>Figure 1</i> ).....	3
<b>Explanation of Collegiate Recovery Asset Survey 2014</b> .....	4
2014 Collegiate Recovery Asset Survey Participants ( <i>Table 1</i> ) .....	6
<b>Introduction to the 38 Assets</b> .....	7
8 Assets Critical to Starting any Collegiate Recovery Effort ( <i>Table 2</i> ) .....	9
14 Additional Assets Essential to Serve and Support Students in Recovery ( <i>Table 3</i> ).....	10
16 More Assets that Can Contribute to a Sustainable Community ( <i>Table 4</i> ) .....	11
2014 Asset Ratings Chart ( <i>Table 5</i> ).....	13
<b>Collegiate Recovery Network Examination</b> .....	15
 <b>Composition</b> .....	16
Staffing and Space Use among Collegiate Recovery Programs/Efforts ( <i>Figures 2-4, Table 6</i> ).....	16
Lifecycle Stages of Collegiate Recovery Communities ( <i>Table 7</i> ) .....	18
Types of Collegiate Recovery Programs/Efforts ( <i>Table 8</i> ) .....	20
 <b>Connections</b> .....	21
Invitations Extended to Student Engagement ( <i>Figures 5-7</i> ).....	22
Community Network Models ( <i>Figures 8-10, Tables 9-11</i> ) .....	25
 <b>Practices</b> .....	31
2014 Practice Ratings Chart ( <i>Table 12</i> ) .....	32
Key Practices by Lifecycle Stages ( <i>Figures 11-14</i> ) .....	33

## ABOUT TRANSFORMING YOUTH RECOVERY

We approach every effort from a capacity-building perspective. This starts by making visible the assets, connections, and resulting practices that can contribute to healthy and thriving lifestyles among young people. Specific attention is given to those at-risk for drug and alcohol substance use disorders or misuse. The 2012 National Survey on Drug Use and Health found that an estimated 23.9 million Americans age 12 and over (9.2% of the population) were current illicit drug users, of which 2.4 million were young people between the ages of 12-17. Additionally, an estimated 9.3 million underage persons (aged 12 to 20) were current drinkers of alcohol in 2012, including 5.9 million binge drinkers<sup>1</sup> and 1.7 million heavy drinkers. This reflects a public health issue that we are looking to address without hesitation.

Our studies seek to find those promising prevention, intervention, and recovery practices that we should be calling upon more often, in more places, with greater consistency. When we find places where such practices live and breathe, we commit to rapidly spreading that knowledge so that connected networks can take collective action.

Our intention is to build networks across boundaries of influence to better reach students, parents, educators, and community leaders. This is undertaken by partnering with those who are committed to the implementation of evidence-based practices that positively impact the well-being of young people and their families.

In all we do, we stay ever mindful that our work aims to positively influence the everyday attitudes and beliefs found in educational, community and social settings. This is a reflection of the idea that change happens one student, one school, one community at a time.

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<sup>1</sup> Retrieved from: <http://www.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/NationalFindings/NSDUHresults2012.htm>

## BUILDING CAPACITY FOR COLLEGIATE RECOVERY PROGRAMS AND EFFORTS

When we first got involved with collegiate recovery, we found a conventional wisdom that colleges lacked the dedicated resources for helping students in recovery fulfill their academic and personal potential. In other words, there was a perception that the problem was a resource gap.

This perception led agencies and institutions to adopt a problem-solving approach and focus on additive activities and services that might address perceived deficiencies.

However, through an asset-based research project funded by The Stacie Mathewson Foundation, we discovered a nearly universally held opinion that the real issue was how to manage access to resources that in many cases already existed. And the real need was for help in building the types of **relationships** that enable students in recovery to take advantage of the full breadth of the collegiate experience.

Consequently, we have pivoted from a program focus to a relationship focus, a migration from problem solving to capacity building. It's a matter of starting with the assumption that college communities already have the resources

and capabilities necessary to help students in recovery to thrive. When you start there, you can then concentrate on removing barriers that may be constraining students in recovery from accessing those assets that could help them thrive in the fullness of their college experience.

Our focus is on stimulating community support for collegiate recovery programs. Our goal is to work toward institutional acceptance and ownership of essential support services in an environment prone to drug and alcohol exposure.

As of June 2014, we have provided toolkits, assistance and \$590,000 in seed grants to 59 colleges and universities striving to find and mobilize collegiate recovery assets that already exist. Additionally, we have awarded \$37,500 in supporting grants to colleges and universities with student populations less than 5000 or established collegiate recovery programs interested in growing their communities.

We are honored to be able to contribute to the broad collegiate recovery movement taking hold in the United States.

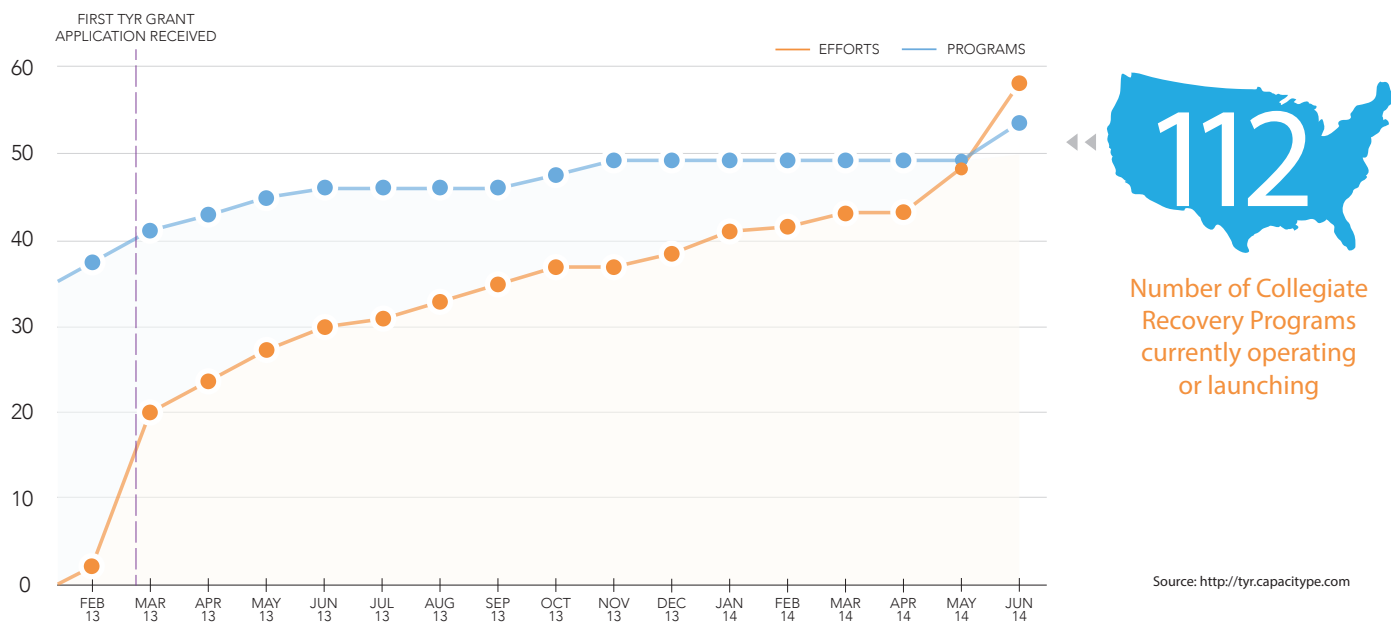


Figure 1. Collegiate Recovery Programs Operating or Launching in the U.S.

## EXPLANATION OF COLLEGIATE RECOVERY ASSET SURVEY 2014

The annual Collegiate Recovery Asset Survey, supported by Transforming Youth Recovery, aims to update studies undertaken to identify community assets that can help students in recovery to thrive in the fullness of the college experience.

The unshakable focus of this work is to develop a methodology for increasing the capacity of a collegiate community to provide students in recovery the assets they need to pursue academic, recovery, and life goals. This survey is not intended to evaluate the effectiveness of any given college-based recovery program or effort. Rather, it is intended to help better understand how certain assets are being mobilized into practices that best support students in recovery.

Survey invitations are extended annually to named program coordinators of collegiate recovery programs or efforts that receive grant funding through Transforming Youth Recovery. The survey asks those coordinators, based on their experience with the collegiate recovery program/effort at their institution, to identify which assets they believe are critical to start serving and supporting college students in recovery and essential to serving and supporting college students in recovery on an ongoing basis, which assets are essential to serving and supporting college students in recovery on an ongoing basis but not critical to start, and which assets are neither critical to start serving and supporting college students in recovery on an ongoing basis nor critical to start serving and supporting college students in recovery.

Starting in 2014, the survey was lengthened to ask program coordinators about the nature of their collegiate recovery program/effort (CRP/E), the relationship between their CRP/E and local community-based assets, and the practices that are a result of their CRP/E.

Results from the survey are used to annually evaluate the usefulness of 38 assets that are the basis for building collegiate recovery capacity across the United States.

To date, asset models have had limited application within the field of collegiate recovery. The application of asset models in this context can aid and inform researchers and practitioners interested in the advancement and proliferation of collegiate recovery programs. The collegiate recovery asset survey instrument is designed to annually refresh and update research originally published in April, 2013 by The Stacie Mathewson Foundation.

38 ASSETS FOR BUILDING COLLEGIATE RECOVERY CAPACITY

Transforming Youth Recovery  
Expanding the Circle of Possibility

# 38 ASSETS

## For Building Collegiate Recovery Capacity

Transforming Youth Recovery has identified a set of 38 community-based assets that are the basis for building collegiate recovery capacity across the nation. These assets reflect the potential college-specific individuals, associations and institutions that can be mobilized to help students in recovery to thrive in the fullness of the college experience.

To assist communities undertaking collegiate recovery efforts, the assets have been categorized to support the progression of a recovery community lifecycle. These categories reflect findings from a 2014 survey of collegiate recovery programs and efforts in the United States.

- The 8 assets that are critical to starting any collegiate recovery effort.
- The 14 additional assets that are essential to serve and support students in recovery.
- The 16 assets that can contribute to a sustainable community of students in recovery.

### Lifecycle of a Recovery Community

Notion	Establishment	Maturity	Sustainability
You are cultivating a small group of students to build a recovery community.	You have a community of students in recovery and are making new relationships to support those students.	You have a formalized collegiate recovery program and community.	You have a formalized collegiate recovery program and are building coalitions to extend the influence of the community.

## BY THE NUMBERS

We invited **44** grantees to take the 2014 collegiate recovery asset survey.

Forty-one grantees completed the survey for a **93%** response rate.

**88%** of the surveyed collegiate recovery programs/efforts started between 2012 and today.

Average enrollment is **23,004** undergraduate and graduate students at grantee institutions of higher education.

**1,525** invitations were extended to participate in collegiate recovery activities, events and services.

From those invitations, **629** students regularly attended activities offered by collegiate recovery programs/efforts.

Twenty-six network models were submitted listing **398** unique community-based assets.

The population of an institution of higher education should be thought of as the **sphere of influence** for any collegiate recovery program or effort (CRP/E). Each CRP/E that responded to the 2014 Collegiate Recovery Asset Survey has, on average, the potential to influence the attitudes and biases of more than 23,000 students.

Going further, the **reach** of community networks forming in and around CRP/Es continues to expand and is a reflection of the invitations extended to participate in recovery-related activities, events, and services

in combination with those community-based assets providing services to students actively engaged in recovery communities. The resulting reach of those CRP/Es responding to the survey was 2,552 community-based assets and students.

Finally, regular attendance at recovery-related activities, events, and services is the indicator of **engagement** which was reported to be 629 students being supported through responding CRP/Es.

## PARTICIPATING COLLEGIATE RECOVERY PROGRAMS/EFFORTS

Name of Institution	Name of Collegiate Recovery Program/Effort	Year started	Formally recognized and endorsed by institution	Undergraduate students served last semester (Fall, 2013)	Graduate students served last semester (Fall, 2013)	Number of staff and volunteers dedicated to CRP/E
Arkansas State University Jonesboro	Astate Collegiate Recovery	2014	Yes	0-5	0-5	4
Auburn University	Auburn Recovery Community	2012	Yes	5-10	0-5	1
Boise State University	(Not yet)	2013	No	10-15	0-5	3
California State University, San Bernardino	STAR (Students Together Advocating Recovery)	2013	Yes	0-5	0-5	1
Dalton State College	Collegiate Recovery Community	2013	Yes	0-5	0-5	2
Florida Atlantic University	(Not yet)	2014	No	0-5	0-5	4
Kennesaw State University	Center for Young Adult Addiction and Recovery	2007	Yes	50+	0-5	9
Longwood University	Longwood Recovers	2013	No	0-5	0-5	3
Michigan State University	Traveler's Club	2013	No	5-10	0-5	7
Mississippi State University	Mississippi State University Collegiate Recovery Community	2013	Yes	5-10	0-5	13
Montana State University	Recovering Students at MSU	2013	No	0-5	0-5	1
Morehead State University	MSU Recovery Program	2013	No	5-10	0-5	4
North Carolina Central University	Alcohol & Other Drug Resource Center	2013	Yes	5-10	0-5	2
Oregon State University	Collegiate Recovery Community	2013	Yes	5-10	0-5	3
Pace University-New York City	Collegiate Recovery Program at Pace University	2013	Yes	5-10	0-5	3
Saint Louis University	SLU Recovery Group	2012	Yes	5-10	0-5	1
St. Cloud State University	St. Cloud State University Recovery Community	2012	Yes	5-10	0-5	14
Stony Brook University	Seawolves For Recovery	2013	Yes	0-5	0-5	2
The Ohio State University	Collegiate Recovery Community	2013	Yes	25-30	10-15	4
The University of Mississippi	(Not yet)	2010	No	5-10	0-5	8
The University of Texas at Arlington	CSR	2014	Yes	10-15	0-5	9
The University of Texas at Austin	The Center for Students in Recovery	2004	Yes	50+	50+	57
The University of Texas at Tyler	Center for Students in Recovery	2013	Yes	0-5	0-5	1
University of California, Riverside	The Loft	2008	Yes	35-40	0-5	5
University of California, San Diego	Triton Recovery Group	2013	Yes	10-15	0-5	1
University of California, Santa Barbara	Gauchos for Recovery	2012	Yes	10-15	0-5	4
University of California, Santa Cruz	Collegiate Recovery Community - CRC	2013	Yes	45-50	0-5	9
University of Connecticut	UConn Recovery Community	2013	No	10-15	0-5	4
University of Houston	Cougars in Recovery	2013	Yes	10-15	0-5	4
University of Massachusetts Boston	UMass Boston Recovery Support Program (Tentative)	2013	No	5-10	5-10	3
University of Michigan	Collegiate Recovery Program	2012	Yes	10-15	10-15	2
University of Nevada, Reno	Nevada's Recovery and Prevention Community (NRAP)	2012	Yes	45-50	0-5	9
University of North Carolina at Charlotte	Collegiate Recovery Community at UNC Charlotte	2012	Yes	0-5	0-5	3
University of North Carolina at Wilmington	CRC Hawks	2013	Yes	10-15	0-5	9
University of North Dakota	(Not yet)	2013	No	30-35	0-5	2
University of South Carolina	Student Health Services Collegiate Recovery Community	2013	No	0-5	0-5	1
University of Virginia	Hoos In Recovery	2006	Yes	10-15	0-5	3
University of Washington	(Not yet)	2013	Yes	10-15	15-20	4
University of Wisconsin La Crosse	(Not yet)	2013	Yes	0-5	0-5	4
Virginia Commonwealth University	Rams in Recovery	2013	Yes	5-10	0-5	9
Wake Forest University	WFU CHOICE Collegiate recovery Effort	2012	Yes	0-5	0-5	5

Table 1. 2014 Collegiate Recovery Asset Survey Participants

## INTRODUCTION TO THE 38 ASSETS

Transforming Youth Recovery has identified a set of 38 community-based assets that are the basis for building collegiate recovery capacity across the nation. These assets reflect potential campus-specific individuals, associations and institutions that can be mobilized to help students in recovery to thrive in the fullness of the college experience.

In 2014, a total of 41 collegiate recovery programs and efforts (CRP/Es) completed the asset ratings portion of the survey. Of those 41, there were 27 (66%) CRP/Es that self-reported being in the early stages of growing their student recovery community.

The original asset survey, administered in 2013, was completed by 19 survey participants without designation of program or effort stage. Of those original 19, only 6 CRP/Es (Longwood University; St. Cloud State University; University of California, Riverside; University of California, Santa Barbara; University of Michigan; The University of Texas at Austin) completed both the 2013 and 2014 asset survey.

The original set of 38 community-based assets that are the basis for building collegiate recovery capacity have been updated to reflect findings from the 2014 Collegiate Recovery Asset Survey. To assist communities undertaking collegiate recovery efforts in the United States, the assets have been designated into three categories to support a progression through a recovery community lifecycle. These categories were determined by asking survey participants to rate each asset according to the following instructions:

\*



In this section, we ask that you consider each of the 38 assets presented individually, and based on your experience and involvement with the collegiate recovery program/effort at your institution evaluate each asset and identify them as one of the following:

- Critical to start serving and supporting college students in recovery and essential to serve and support college students in recovery on an ongoing basis (numeric rating of 1.00)
- Essential to serve and support college students in recovery on an ongoing basis but not critical to start serving and supporting college students in recovery (numeric rating of 2.00)
- Neither critical to start serving and supporting college students in recovery on an ongoing basis nor essential to serve (numeric rating of 3.00)

Assets can be individual—such as people who can help students in recovery build self-efficacy; they can be associational—such as mutual aid support groups near or on campus for students in recovery, and they can be institutional—such as a physical space that is dedicated for students in recovery to gather and meet.

\* THE SURVEY QUESTION - [  ]

Given the increase in collected survey data (from 19 survey participants in 2013 to 41 participants in 2014) and the instructional change to evaluate and rate community-based assets from respondents' personal experience with the CRP/E at their institution (versus from one's personal experience at-large), the rules applied for determining asset categories were adjusted slightly for 2014 reporting purposes.

- 8 community-based assets were indicated by 60% or more survey participants and those self-reporting as being in the early stages of growing their student recovery community as **critical to starting any collegiate recovery effort**. (*Table 2*) Assets that were indicated by 60% or more survey or early stage survey participants as critical to starting any collegiate recovery effort were included in the category if the asset also appeared in the top quartile of the 2014 Asset Ratings.
- 14 additional community-based assets were categorized as **essential to serve and support students in recovery** if the asset received a rating below 2.00 in the 2014 Asset Ratings or was indicated by 50% or more survey participants as essential to serve and support students in recovery. (*Table 3*)
- Finally, 16 more community-based assets were categorized as **contributing to a sustainable community of students in recovery** given that no presented asset received a rating of 3.00 (which would denote that the asset was neither critical to start a collegiate recovery effort nor essential to serve and support students in recovery.) (*Table 4*)



## 8 ASSETS CRITICAL TO STARTING ANY COLLEGIATE RECOVERY EFFORT

Categorized as critical to starting any collegiate recovery effort if indicated by 60% or more of the survey population and those self-reporting as being in the early stages of growing their student recovery community ; or, indicated by 60% or more of the survey or early stage survey participants and appearing in the top quartile of the 2014 Asset Ratings (see page 13).

	Survey Pop. (N=41) % ranked Critical to start	Early Stage Pop. (N=27) % ranked Critical to start
Students in recovery who are interested in growing the recovery community on-campus.	95%	96%
Mutual aid support groups near or on campus for students in recovery (i.e. AA, NA, GA, and other 12-Step meetings in addition to groups such as Celebrate Recovery, SMART Recovery, eating disorder recovery, Teen Challenge, etc.).	85%	81%
Individuals who are dedicated staff for a collegiate recovery program (faculty, staff, students; full or part-time).	80%	74%
Physical space for students to get together socially, soberly, and safely (organized meals, dances, bowling or other age-appropriate activities).	76%	78%
Physical space that is dedicated for students in recovery to gather and meet.	66%	70%
Organizations, departments and services that a collegiate recovery program can refer students who need outside services (treatment centers, mental health professionals, counselors, psychologists, etc.).	66%	70%
Individuals who are influential within the University and/or in the broader community and are interested in advocating for students in recovery.	61%	63%
Students in recovery who are interested in mentoring other students in recovery (vocational, recovery, or as a general role model).	61%	59%

Table 2. 8 Assets Critical to Starting any Collegiate Recovery Effort

Early stage CRP/Es are detailed on page 18.

### SURVEY COMMENT



*What has been most critical in our experience has been having at least one full-time staff member who can serve as the constant support, the advocate, and the collaborator on campus. Once momentum and traction has been gained, it is essential to hire additional staff as the program grows in order to make all of campus more recovery-oriented.*



## 14 ADDITIONAL ASSETS ESSENTIAL TO SERVE AND SUPPORT STUDENTS IN RECOVERY

Categorized as essential to serve and support students in recovery if the asset received a rating below 2.00 in the 2014 Asset Ratings (see page 13) or was indicated by 50% or more survey population.

	Survey Pop. (N=41) % ranked Critical to start	Survey Pop. (N=41) % ranked Essential to serve
Appropriate and protective housing options for students in recovery (sober roommates, floors, buildings, etc.).	29%	56%
Individuals available for 1:1 recovery support (coaching, guiding, supporting, mentoring).	56%	34%
Individuals available to assist with fundraising in support of a collegiate recovery program (i.e. write grants, solicit donations, run fund raisers, etc.).	46%	47%
Individuals licensed or trained to support both mental health (ADHD, anxiety, depression, etc.) and substance use disorders (alcohol and other drugs).	46%	41%
Individuals from medical services (medical doctors, psychiatrists, psychologists and other licensed counselors) available to provide students in recovery with medical treatment (prescriptions, referrals, etc.) specific to mental health (ADHD, anxiety, depression, etc.) and substance use disorders (alcohol and other drugs).	32%	51%
Individuals trained as drug and alcohol counselors in the areas of addiction and recovery.	41%	46%
Individuals who can help students in recovery build self-efficacy (confidence, social skills, budgeting, general life-skills, etc.).	39%	51%
Individuals who can provide students in recovery with academic guidance (i.e. tutoring, counseling, etc.).	37%	54%
Individuals who can serve as positive mentors (professional, recovery, or as a general role model) for students in recovery.	32%	56%
Organizations, departments and services that can provide operational support to a collegiate recovery program (endowments, foundations, University departments, institutional funds, etc.).	59%	32%
Organizations, departments and services that can provide the general population (students, faculty and staff) with education and training to increase understanding of substance use disorders and recovery (presentations, newsletters, events, orientations, new hire training, etc.).	39%	51%
Organizations, groups and clubs that can provide students in recovery access to recovery resources in the broader community (support programs, wellness resources such as yoga or meditation, etc.)	22%	71%
Organizations, departments and services that can refer students to a collegiate recovery program (judicial affairs, academic counselors, mental health counselors, treatment centers, etc.).	54%	46%
University support for students in recovery in the form of funding, promotion, recognition, and/or staff assignment.	54%	37%

Table 3. 14 Additional Assets Essential to Serve and Support Students in Recovery

### SURVEY COMMENT

“ We have just begun our Recovery Community and we have made significant progress so far. The barriers that we are starting to hit that will slow down our progress include a funding stream for the recovery community. ”

“ [We are a] student organization, but the University has begun to recognize us by agreeing to start a pilot program for housing for students in recovery. ”

## 16 MORE ASSETS THAT CAN CONTRIBUTE TO A SUSTAINABLE COMMUNITY OF STUDENTS IN RECOVERY

Remaining assets categorized as contributing to a sustainable community of students in recovery. (No present-ed asset received a rating of 3.00 in the 2014 Asset Ratings (see page 13) which would denote that the asset was neither critical to start a collegiate recovery effort nor essential to serve and support students in recovery.)

	Survey Pop. (N=41) % ranked Critical to start	Survey Pop. (N=41) % ranked Essential to serve
Departments within the University involved in or supporting ongoing research on addiction and recovery.	7%	34%
Departments within the University that offer courses on subjects related to addiction and recovery for course credit.	7%	30%
Individuals from the collegiate recovery program who have graduated and are interested in supporting students in recovery.	5%	59%
Individuals from the university community (alumni, parents, advocates) interested in supporting students in recovery.	5%	61%
Individuals in student residential settings who are trained to identify potential addiction issues.	10%	63%
Individuals interested in recovery who can use their personal network within the broader community to help students in recovery to find vocational opportunities (such as internships, sponsored research, etc.).	20%	54%
Individuals who can provide students in recovery with legal assistance (i.e. consultation for referrals, expunge-ment of records, etc.).	2%	54%
Individuals who can provide students in recovery with spiritual guidance where spiritual guidance is defined as the exploration of personal values and development of a purpose-driven life.	20%	39%
Organizations, departments and services that can help students meet basic needs (food, safe shelter, etc.).	37%	49%
Organizations, groups and clubs that enable students to gain and practice leadership skills (through intern-ships, community service, mentoring, through participation in student-led organizations, etc.).	15%	49%
Organizations, groups and clubs that facilitate involvement in community service, philanthropy and civic engagement (speaking at high schools, service projects, etc.).	24%	39%
Organizations, groups and clubs that have an interest in supporting students in recovery (i.e. community, religious or school organizations).	20%	59%
Organizations, groups and clubs that help students enhance their physical health and wellness (nutrition information, fitness programs, health screenings, stress and anxiety, meditation, etc.).	24%	51%
Organizations that promote awareness of collegiate recovery beyond the University (peer groups, government programs, research, associations, etc.).	34%	49%
Organizations that provide financial assistance for students in recovery (scholarships, grants, etc.).	24%	46%
Students in recovery who are trained to lead and facilitate groups.	22%	49%

Table 4. 16 More Assets that Can Contribute to a Sustainable Community

### SURVEY COMMENT



*I marked many of them as “Not Essential”, but it certainly doesn’t mean that I don’t see them as valuable assets. I see them more as fantastic bonus opportunities if you have them available to your students. But the absence of them wouldn’t hinder the start or continuation of a successful recovery support program.*



**Full report available at:**

**<http://bit.ly/1Gv9zwQ>**

## **STATEMENT AGAINST LEGALIZATION OF MARIJUANA**

As the nation's largest nonprofit provider of addiction prevention, treatment and recovery services, the Hazelden Betty Ford Foundation has an important responsibility, and is uniquely qualified, to comment on the effects of marijuana use, which we see every day among the people we serve at our 15 locations around the country.

We know marijuana is dangerous to many users and addictive to some, and that young people are particularly vulnerable. While the debates over legalization continue, many young people view marijuana as less risky, and not surprisingly, more and more of them are smoking marijuana for the first time.

Early use of marijuana is especially troubling. The human brain develops throughout adolescence and well beyond. Marijuana use can harm learning, thinking and memory development and can contribute to mental health issues, not to mention medical problems. We also know the earlier a young person starts to use any mood and mind altering substance, the greater the possibility of developing addiction. One of the recurring themes we hear from the youth we treat is regret – of wasted time, lost opportunities, squandered talent, impaired memory, reduced performance and disinterest in healthy activities.

Expanded social acceptance will almost certainly result in more new users, higher frequency of use among established users and increases in marijuana-associated health and social problems.

Therefore, the Hazelden Betty Ford Foundation opposes any efforts that increase the availability of marijuana and minimize the dangers of its use.

We believe strongly in the paramount importance of educating the public, especially young people and their parents, about the dangers and potentially addictive dynamics of all drugs, including marijuana.

And, while we oppose the use of marijuana as a “medicine” unless it has been approved by the U.S. Food and Drug Administration (FDA), we understand the cannabis plant has some medicinal qualities and support further research.

While there are a number of additional issues and proposals surrounding the wider marijuana debate, we believe our expertise, experience and energy is best applied to educating the public about the dangers of expanded drug and alcohol use as well as the promise and possibility of recovery.

This statement reflects the Hazelden Betty Ford Foundation's clear and singular aim of reducing the harmful impact of addiction.

## Learn More and Take Action

Get Informed. Get Involved. Share Your Voice.

Our website **HBFinstitute.org** includes:

- Advocacy events
- Relevant news and legislation
- Position papers
- Speakers bureau
- An online Social Community
- Latest survey data and other research
- Blogs by William C. Moyers and others
- Personal stories
- Opportunities to take action



**HBFinstitute.org 651.213.4568**

We invite you to call us with questions.  
We are available 24 hours a day.

Our mission is to provide a leading national voice on all issues related to addiction prevention, treatment and recovery and to facilitate conversation among those in recovery, those still suffering and society at large. We are committed to smashing stigma, shaping public policy and educating people everywhere about the problems of addiction and the promise of recovery.

The Hazelden Betty Ford Institute for Recovery Advocacy is part of the Hazelden Betty Ford Foundation, the nation's largest nonprofit treatment provider. With a legacy that began in 1949 and includes the 1982 founding of the Betty Ford Center, the Foundation has 16 sites in California, Minnesota, Oregon, Illinois, New York, Florida, Massachusetts, Colorado and Texas.

800.257.7800



## INSTITUTE FOR RECOVERY ADVOCACY

A national voice  
and thought leader.



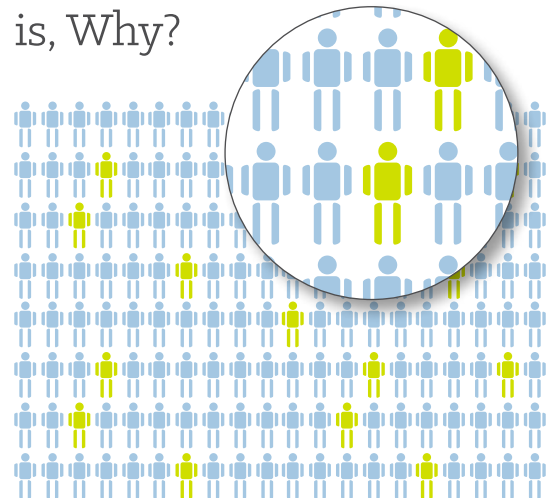
## The First Lady of Recovery Advocacy



Former First Lady Betty Ford put a courageous face on recovery in 1978 when,

at age 60, she openly sought treatment for addiction to alcohol and prescription medications. Her candor created a national dialogue and lifted the shame surrounding addiction, unlocking the door to recovery for many people, especially women. She represents our strong advocacy roots at the Hazelden Betty Ford Foundation—roots that also include important contributions to landmark parity legislation, robust public education initiatives, and leadership establishing a modern recovery advocacy movement built on reducing stigma by highlighting the positive faces and voices of recovering people. With roots so strong, the Hazelden Betty Ford Institute for Recovery Advocacy is now a leading voice on matters related to addiction prevention, treatment, and recovery, with a focus on addressing America's opioid crisis.

More than 20 million Americans have a substance use disorder. About 90% of them do not get treatment. The question is, Why?



### The Hazelden Betty Ford Institute for Recovery

**Advocacy** is committed to smashing stigma, shaping public policy, and educating people everywhere about the problems of addiction and the promise of recovery.



# **SPEAKING UP AND WEIGHING IN**

Our mission is to facilitate conversations among those in recovery, those still suffering, and society at large. To replace misinformation with understanding. Misperception with empathy. Denial with hope. We are a powerful community. Our lives prove that recovery is possible, and our stories inspire action. Together, we are a force that can overcome stigma and serve as a hopeful beacon for those who still need help.

**[HBFinstitute.org](http://HBFinstitute.org)**

**651-213-4568**

**800-257-7800**





# Now is the time

Reduce stigma

Lead the way nationally in promoting the most-effective treatment and recovery protocols

Eliminate barriers to individuals seeking recovery

Create a national voice to help shape public dialogue, opinions, attitudes, and policy

Be the premier, go-to resource on addiction prevention, treatment, and recovery issues



## **GETTING INVOLVED** in the Fight *against* Addiction and *for* Recovery

The stigma of addiction remains a major barrier to seeking help and a source of subtle discrimination. We are committed to helping smash stigma by shining light on the positive faces and voices of those who recover.

## **EDUCATING** about the Risks and Costs of Marijuana Legalization

We know marijuana is dangerous to many users and addictive to some and that young people are particularly vulnerable. These facts cannot be lost in the ongoing debates over legalization.

## **PREVENTING** Alcohol Misuse and Addiction

We support regulation of alcohol advertising, increases in alcohol taxes, and a number of state and local initiatives that can reduce underage drinking, binge drinking, and alcohol-related illness and death.

## **IMPROVING** Access to Addiction Care and Support

We are committed to educating consumers about their rights and opportunities under health care reforms such as the "parity" law and Affordable Care Act. We also support state and local efforts to expand and promote access to care.

## **DEVELOPING** Sentencing Alternatives

Most inmates in our prisons are there in part because of substance use problems. We support drug courts, sentencing that promotes treatment and reintegration, and the redemptive possibility of earning a clean criminal record.

## **CONFRONTING** the Opioid Crisis

The expanded availability of prescription painkillers and heroin has created a public health crisis that demands attention from the government and communities nationwide.



Hazelden Betty Ford  
Institute for Recovery Advocacy

# Coverage for Addiction and Mental Illness: *Now It Is the Law*

How to be your best advocate when working  
with your health insurance company



**INSTITUTE  
FOR RECOVERY  
ADVOCACY**

***Get the answers you  
need to questions about your  
addiction treatment.***

## Hope starts with help

In 2010, millions of people and their families who needed help for addiction to alcohol or other drugs gained a new resource: health insurance. A federal parity law expanded access to treatment by prohibiting most insurance plans from restricting coverage or imposing unequal limitations on treatment options. Even though insurers and employers are aware of this new law and their required compliance, it is up to you, the consumer, to make sure you or your loved ones receive the resources for treatment you need and deserve. Know your rights. Don't be afraid to stand up and speak out for the benefits required under the law.

**Ask questions. Get clarification. Negotiating with your insurance provider can be stressful and difficult. Don't give up.**

## Who you need to contact

- Call Member Services at your insurance company.
- Have your membership identification ready.
- Write down the name of the Member Services representative who talks with you.
- Take notes of your conversation.
- If you have employer-sponsored coverage, advise your human resources professional that the plan appears to be noncompliant.

## Questions you need to ask

- What "levels of care" are covered for addiction treatment? (Examples of levels of care include: inpatient, outpatient, residential, hospital-based, and partial hospitalization.)
- Please clarify which in-network and out-of-network behavioral health and medical providers I have access to. And, what percentage of behavioral health and what percentage of medical benefits does my plan cover?
- What is my out-of-pocket maximum expense?
- What criteria do you use to determine medical necessity?



## Quick answers to key questions about expanded coverage

### What are the new law's basic requirements?

Employer-sponsored group health plans can no longer discriminate in their coverage of addiction and mental health benefits. If they do, they must have financial requirements and treatment limitations that are no more restrictive than those placed on medical or surgical benefits. This applies to out-of-pocket expenses, copayments and deductibles, as well as medical management criteria related to “medical necessity,” “prior authorization,” “concurrent review,” and “utilization review.”

### Are there exceptions?

Grandfathered small group plans that were in existence before March 23, 2010, are exempt; otherwise, small group plans must now comply. Also, the new federal law protects any stronger state laws mandating coverage for addiction and mental health treatment.

### What happens if I seek treatment resources that are not within my plan's network?

Choosing to go out-of-network no longer means you are out of luck. An insurer that provides benefits for addiction and mental illness treatment and that provides out-of-network coverage for medical/surgical benefits must provide *equal* out-of-network coverage for addiction and mental illness treatment.

### Does the law apply to other health plans?

Yes. In addition to group health plans and insurers, Medicaid-managed care plans and state children's health insurance programs are included. Plans sold under the insurance “exchanges” of the Affordable Care Act (ACA) are also covered by parity, and they must provide addiction coverage as an “essential benefit.”

### What can I do if I am denied treatment or my options are restricted?

The new law requires that the insurer must, upon request, provide you with the reason for the denial. If the plan says service was not “medically necessary,” you are entitled to request and receive the plan's medical necessity criteria specific to

mental health and addiction treatment coverage. Visit the Parity Implementation Coalition ([ParityIsPersonal.org](http://ParityIsPersonal.org)) for more information.

## Glossary of Terms

### **Affordable Care Act**

The federal law that expands access to health insurance. One of the “essential health benefits” under the law is addiction coverage.

### **Coinsurance**

An amount an individual may pay for services after a deductible has been paid. Coinsurance is usually a percentage of what the health care provider will receive for the services. For example, the individual pays 20 percent of the charges for a service and the insurer pays 80 percent.

### **Copayment**

A predetermined flat fee an individual pays for health care services, after a deductible has been paid and in addition to what the plan or insurer pays. For example, some plans may require a \$50 copayment for each office visit.

### **Day Limit**

Maximum number of days of coverage available through your insurer.

### **Deductible**

The amount an individual must pay for health care expenses before an insurer covers the costs. Often, coverage includes yearly individual and family deductible amounts.

### **Denial of Claim**

Refusal by an insurer to cover an individual's health care services.

### **Explanation of Benefits (EOB)**

An insurer's written explanation to a claim, showing what they



**Don't be intimidated by the tangle of terms and conditions when trying to use your health care coverage. Ask for clarification when you don't understand. Get the answers you need.**





paid and what the client must pay. If the claim is partially or wholly denied, the EOB will describe a process for appeal. Grandfathered plans, or those that were in place before March 23, 2010, may be exempt from the ACA and Mental Health Parity and Addiction Equality Act requirements.

**In-Network Providers** Physicians, hospitals, and other health care providers that have contracts with an insurer to provide services to its members, usually at discounted rates. Individuals with coverage usually pay less when using in-network providers because of those negotiated discounts.

**Inpatient** Health care services provided on an inpatient basis, meaning the individual stays overnight at an inpatient facility, typically a hospital.

**Maximum Dollar Limit** The maximum amount an insurer will pay for claims within a specific time period.

**Medical Necessity** Criteria used by insurers or their review agencies to determine coverage for various levels of care. Each reviewer may use a different set of criteria. One common set of criteria for mental health and addiction treatment coverage determinations comes from the American Society of Addiction Medicine ([ASAM.org](http://ASAM.org)).

**Out-of-Plan/Out-of-Network** Physicians, hospitals, and other health care providers that are not contracted with the plan or insurer to provide health care services at discounted rates. Depending on an individual's plan, expenses incurred by services provided by out-of-plan health care professionals may not be covered or may be only partially covered.

**Out-of-Pocket Limit** A predetermined amount that an individual must pay before the plan or insurer will pay 100 percent for an individual's health care expenses. Out-of-pocket limits are usually applied on a yearly basis.

**Outpatient** Health care services provided on an outpatient basis, meaning the individual does not stay overnight at an inpatient facility, such as a hospital.

**Parity** The Mental Health Parity and Addiction Equality Act of 2008, which is a federal law designed to protect mental health and/or substance use coverage benefits.

**Precertification** An insurer's review of an individual's health care status or condition that usually occurs prior to an individual being admitted to an inpatient facility, such as a treatment center. Precertification is part of determining health care coverage and might involve meeting medical necessity criteria.

**Preexisting Condition** A coverage limitation that may apply when an individual's health care coverage changes, as from one insurer to another or one employer to another. The limitation states that certain physical or mental health conditions, either previously diagnosed or that would normally be expected to require treatment prior to coverage under the new policy, will not be covered under the new policy.

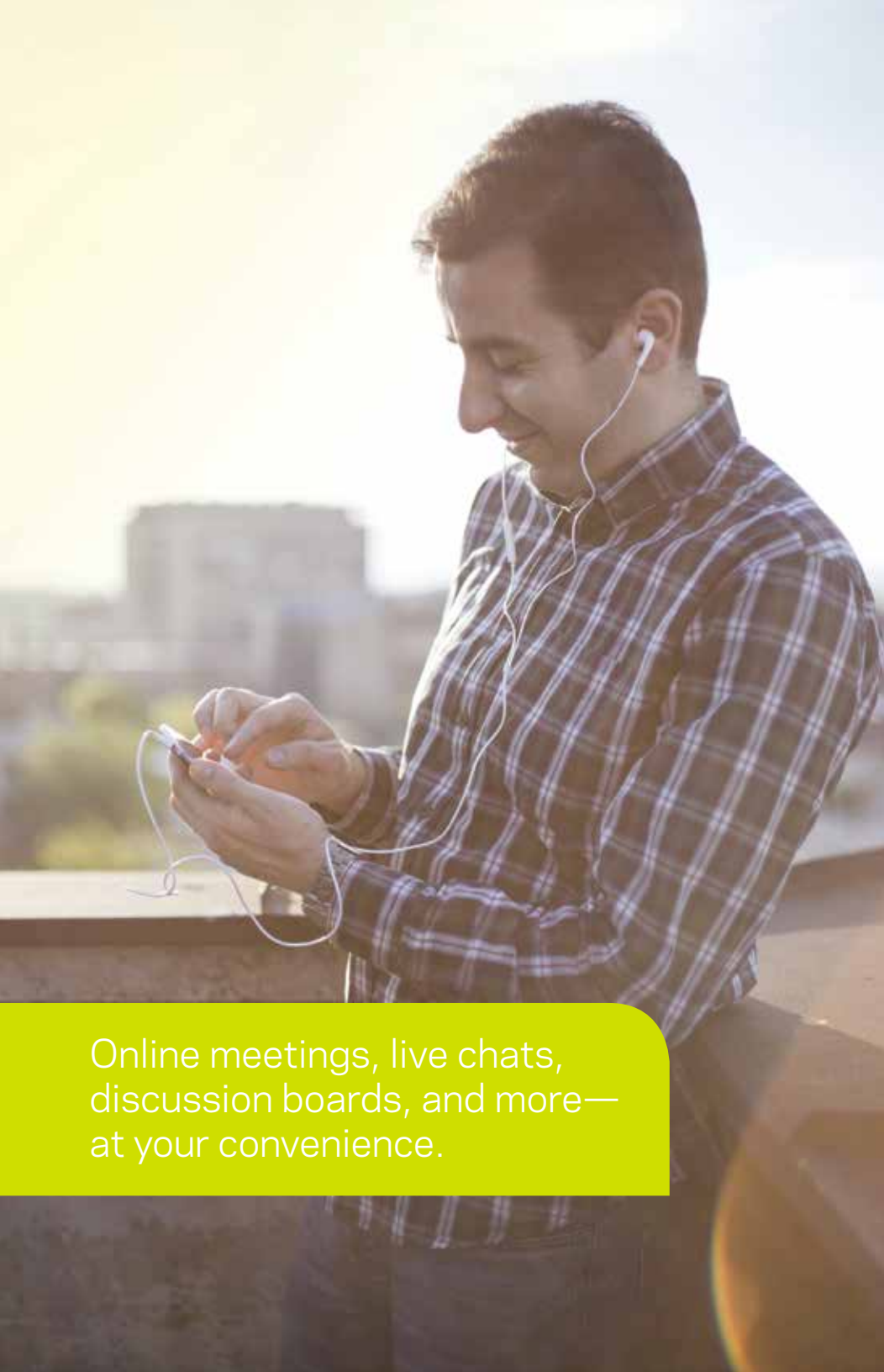
**Reasonable & Customary Fees/Usual & Customary Fees (U&C)** The average fee charged by a particular type of health care practitioner within a geographic area. These fees are often used by insurers to determine the amount of coverage for health care provided by out-of-network providers. The individual may be responsible for any copayment, coinsurance and deductible, as well as any remaining portion of the provider's fee that is not covered by the Reasonable & Customary Fee.

**Residential** Health care services such as chemical dependency treatment in a residential setting that is not hospital based but is, rather, a freestanding facility.

[illegible]

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Online meetings, live chats,  
discussion boards, and more—  
at your convenience.

**HAZELDEN BETTY FORD LOCATIONS**

AURORA, COLORADO  
BEAVERTON, OREGON  
BOSTON, MASSACHUSETTS  
CENTER CITY, MINNESOTA  
CHASKA, MINNESOTA  
CHELSEA, NEW YORK  
CHICAGO, ILLINOIS  
IRVING, TEXAS  
MAPLE GROVE, MINNESOTA  
NAPLES, FLORIDA  
PLYMOUTH, MINNESOTA  
RANCHO MIRAGE, CALIFORNIA  
SPRINGBROOK, OREGON  
ST. PAUL, MINNESOTA  
TRIBECA, NEW YORK  
WEST LOS ANGELES, CALIFORNIA

**[HazeldenBettyFord.org/social](https://HazeldenBettyFord.org/social)**

**800-257-7800**

We invite you to call us with questions.  
We are available 24 hours a day.



The Hazelden Betty Ford Foundation helps people reclaim their lives from the disease of addiction. It is the nation's largest nonprofit treatment provider, with a legacy that began in 1949 and includes the 1982 founding of the Betty Ford Center. With 16 sites in California, Minnesota, Oregon, Illinois, New York, Florida, Massachusetts, Colorado, and Texas, the Foundation offers prevention and recovery solutions nationwide and across the entire continuum of care for youth and adults. It includes the largest recovery publishing house in the country, a fully-accredited graduate school of addiction studies, an addiction research center, an education arm for medical professionals and a unique children's program, and is the nation's leader in advocacy and policy for treatment and recovery.

# A Social Community Built for You—and by You



Be a part of our member-powered online recovery  
community—your confidential, anytime, anywhere hub  
of support, fellowship, and resources.



# Join our Social Community

Whether you are concerned about a loved one and looking for a ray of hope or seeking to strengthen your own recovery by connecting with others who understand, the **Hazelden Betty Ford Foundation's** online recovery community brings a world of fellowship to you 24/7. It's your safe, always-accessible "people helping people" place for wisdom, inspiration, and healing.

**[HazeldenBettyFord.org/social](https://HazeldenBettyFord.org/social)**

## Being there, for each other

**As a member of our Social Community, you're part of a worldwide group of "people helping people 24/7."**

**[HazeldenBettyFord.org/social](https://HazeldenBettyFord.org/social)**

- Attend online support meetings
- Read and participate in lively discussions
- Chat with others any time of day
- Connect with others who have loved ones struggling with addiction
- Find help and resources for co-occurring conditions
- Read the latest recovery news
- Take advantage of personal recovery tools (private journal, recovery tracker)
- Search a vast recovery database
- Access exclusive Hazelden Book Club content, promotions, and events
- Share common experiences by joining groups based on your interests, locale, profession, cultural background, ethnic heritage, and more
- View videos and listen to podcasts
- Follow blogs written by experts in the field
- Gain inspiration from daily meditations



### **Membership is free.**

You control your anonymity settings. Designed for those in recovery as well as family members and friends.

