A Recovery Community Guide for Public Health

November, 2020

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Public Science Collaborative
Science consulting for the public good

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Key Terms

Recovery Community Centers (RCC) are community-oriented, local organizations developed around the concept of social capital incubators. The center links members of the recovery community to different support services and recovery resources near them. Peer mentors facilitate the accrual of recovery capital by linking members to, for example, recovery coaching, medication assisted treatment, employment or education linkages. Located in the heart of the community, Recovery Community Centers often support mobilization efforts, peer support meetings, service and community outreach activities, and destigmatize campaigns.

Recovery Community Organizations (RCO) are the organization where decisions are made, advocacy is enacted, funds are distributed, and expertise is shared throughout the state-wide network. RCOs do not require a physical space (may be entirely virtual), but many of the people we spoke with were housed in a building. Some RCO's had office space within an RCC they supported; others were centrally based in a capital or otherwise important city in the state. Overall, an RCO should be strategically positioned to provide services to its partner RCCs and to do fundraising and advocacy work in the local environment.

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Summary of Work

In partnership with the Iowa Department of Public Health Substance Abuse Bureau, this project solicited feedback from leaders of substance use recovery throughout the country to identify best practices for developing **Recovery Community Centers (RCCs)** and **Recovery Community Organizations (RCOs).** The goal of this work was to develop a data-informed roadmap for RCC/RCO development in Iowa.

National and local Recovery Community Center directors shared stories of their organizations' founding experience (what worked, what did not, and why they were successful), funding model, staffing structure, and ultimately, advice on how Iowa should approach the development of a formal, statewide network of recovery. Their input reflected a wealth of diverse approaches to creating a sustainable substance use disorder (SUD) recovery ecosystem, which we highlight in this report and in supporting documents, including our:

- Recommendations for developing Iowa's Recovery Community.
- Reflections on how RCCs/RCOs can support Iowa-specific recovery needs, with special attention to economic vulnerability, trauma, and social isolation.
- Recovery Community Start-up Toolkit containing documents and examples from local and national leaders that can support Iowa's recovery network expansion.
- Imagery of RCCs nationwide that illustrate safe, clean, and thriving community centers operating throughout the country.
- National Registry of Recovery Community Centers and Recovery Community Organizations.

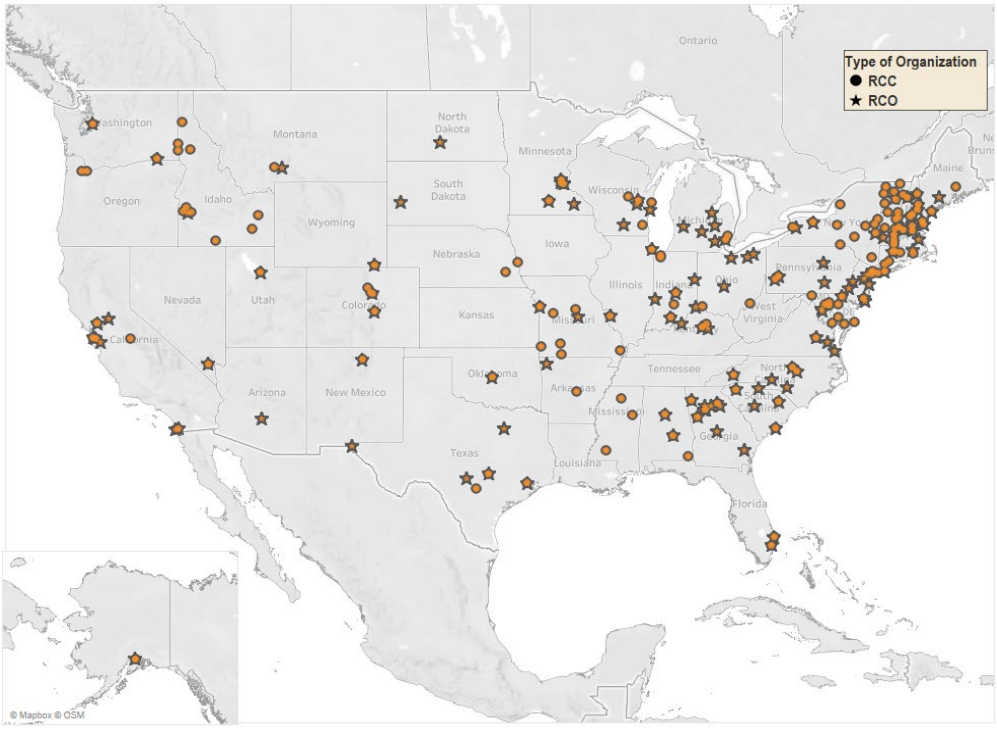
Our Approach

As a starting place, the *Public Science Collaborative* team sought advice from recovery community leaders around the country who had experience founding and managing a successful recovery community center or recovery organization to learn from their experiences. To identify national recovery community leaders, our team needed a national registry of RCCs and RCOs, from which interview participants could be selected to join our study. Unfortunately, a comprehensive list did not exist, though a partial one could be obtained by culling contact information from the national RCC member association, ARCO. Because many recovery communities throughout the country are not members of ARCO, our team conducted an environmental scan of current RCCs and RCOs, producing, to the best of our knowledge, the first, and most comprehensive national registry of U.S. based RCCs and RCOs. This dataset is visualized in Figure 1, where we spatially mapped the location information contained in the national registry data set (the registry is included among the several contract deliverables to IDPH). Our registry includes 169 RCCs and 152 RCOs spanning 45 states.[1]

We used the national recovery community registry to select 28 leaders for interviewing based on four criteria: (1) we initially prioritized states that were regionally and demographically similar to Iowa and that had well-established recovery networks; and (2) we included organizations that were both recently founded and long-standing to ensure we obtained a broad range of founding experiences and challenges associated with organizational maturation. Over the course of our interviews, we began to hear fewer and fewer new stories from our interview participants (what ethnographers refer to as saturation), which led us to transition to two additional participant selection criteria. Once a saturation of ideas was met with our first two criteria, we emphasized diversity by geography and community type by (3) ensuring we interviewed community recovery leaders from

[1] Some RCCs also function as an RCO. In these instances, a single organization is considered both an RCC and an RCO.

Figure 1. RCC and RCO National Registry



each of the Census Bureau's four main geographic regions in the US; and (4) selecting cities with populations of more than 100,000, between 25,000-100,000, and less than 25,000. In total, we spoke to 28 RCC and RCO leaders from 27 organizations in 24 states that reflected a wide range of experiences and community types (see Figure 2).

Guided by a roughly 60-minute semi-structured interview protocol, we asked recovery community leaders how they became involved in substance use disorder recovery; the founding story of their RCC; how they established a sustainable revenue model and what form it took; the nature of their organization's operating procedures and guiding principles; the RCC site selection process for their organization; successful strategies for community engagement; and a wide range of personal and organizational stories that highlighted both their successes and their failures. An example of the RCC protocol we used is in the Appendix. We gave attention to what worked for these recovery leaders and also to what didn't work and why. By hearing about their successes and their failures, our team gained valuable insights into what might work best for Iowa. The core recommendations are highlighted in Figure 3 and the text that follows. At the end of each interview we invited participants to share resources they found helpful when setting up their own RCC or RCO, which we provide as a stand-alone RCC Startup Toolkit.

We were amazed by, and grateful for, the generosity of the people we spoke with, in terms of sharing their time and expertise, and offering to be of help in the future. Every leader we spoke with shared important wisdom and information; they also became instant cheerleaders for the efforts of Iowa to create a recovery network. Though

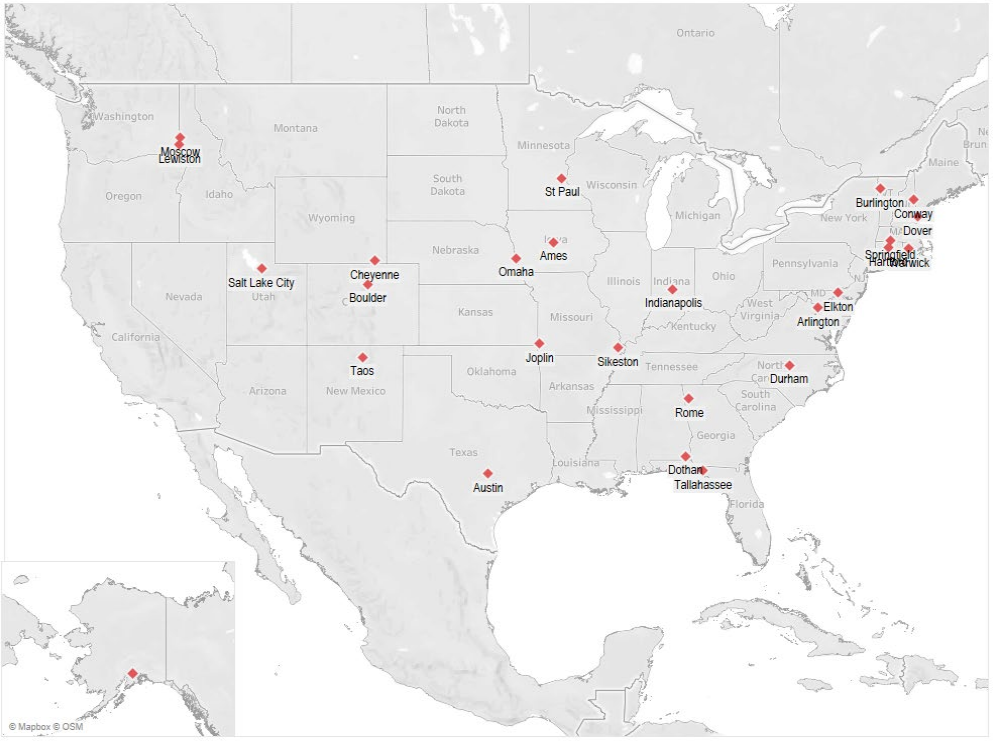
Data Insight: Expand Diversity of Interviews to Meet Iowa's Needs

A significant geographic pattern emerged when we mapped and analyzed RCC locations nationwide: *virtually all successful RCCs were founded in very large cities and only a limited number of instances could be identified where RCCs were founded in smaller towns*. Because the majority of Iowa's towns are small and midsized (U.S. Census Bureau, Population Division, 2020), we included interviews with RCC leaders from smaller communities, and in states and regions with similar demographic characteristics as Iowa, as well as criteria related to founding date and across each region of the United States.

this sample is by no means random—that is, we talked to the people who answered and were excited to speak with us about their work in the recovery community—it is strong in information, energy, and connections that IDPH can leverage in future RCO and RCC development efforts.

Strategies for Building a Resilient Recovery Community in Iowa

Figure 2. Location of Interview Participants



"What setbacks did you face in founding the RCC or have you faced in the recent past?"

Near the end of each interview, we asked this question of recovery community leadership, and heard a variety of frank and helpful advice. Some setbacks were logistical and unplanned—like the rent of a space being raised, or the retirement of a valuable member of the leadership team—but many setbacks were shared to us as things that we should consider in starting a recovery network in Iowa. Below, we present eight themes, or principles, that emerged from the advice we received from the leaders of successful recovery communities.

Recommendations from Recovery Community Leaders

- *Use recovery-specific language.* RCC leaders emphasized the importance of language—recovery requires a longer-term commitment than treatment, and must be presented to the community, funders, and people who use substances in this way. Our respondents advised us to find ways to circumvent a treatment-centered approach and instead help community leaders to understand that recovery is long-term process.

  Most all of the leaders we interviewed used some form of the "peer-to-peer" or "recovery" language, with a few notable exceptions. Though "peer-to-peer" was the most used term to describe the kind of mentorship and coaching that RCCs provided to people in recovery—peer-to-peer coaching, peer-to-peer support services, etc.—at least one of our high-profile respondents rejected this terminology. "The term makes me bristle […] A peer is someone close to you in age, not necessarily someone with an addiction in recovery". This respondent preferred the term "Recovery Coach," citing the etymology of the word coach.

"The word comes from the word for 'carriage'—a carriage conveys a valued person from where he or she was to where he or she wanted to be." Another respondent strongly rejected using "recovery" in the work of their organization, using instead "peer-to-peer support and genuine human relationships." This respondent discussed how, in their eyes, the word recovery further stigmatizes the population and topic it supports, arguing that de-stigmatization should be a priority of the movement.

Overall, we found that language and definitions are foundational to much of the work that recovery communities do. Though we discuss both RCCs and RCOs in this report, and make use of terms like "peer-to-peer support" and "recovery coaching," the recovery community of Iowa and any entities that spring

Figure 3. Recommendations from National and Local Recovery Community Leadership

from the energy of this research partnership are encouraged to purposefully plan for the language and definitions future work will use. Though we do not recommend one terminology over the other, we note that language conveys meaning, images, and oftentimes signals harmful and inaccurate stereotypes around substance use (e.g. dirty/clean, addict, drug user). SUD language is in a period of transition, with some people already fluent in the emergent, new language of recovery, but many more people are not yet familiar with new terminology. For this reason, we urge patience and role modelling among those who seek to update the language of SUD recovery. The leaders of Iowa's RCCs will need to be bi-lingual, familiar with contemporary SUD language as well as the older language that is common in communities throughout Iowa. Given the important community outreach role of RCC leaders, it is critical that they be welcoming of SUD allies who may still rely on language viewed as outdated within the recovery community.

- *Create allies, not competitors*. RCC leaders emphasized the importance of creating strong alliances among those working in the SUD treatment community and those providing recovery services. Key to these alliances is strong outreach, human connection, and good marketing. As one leader told us, "We don't compete as an RCC, we should be a center, kinda like Switzerland. We have to be a place for the community to come together". Ensuring that treatment centers and treatment service providers understand that Recovery Community Centers exist to support long-term, post-treatment recovery will go a long way toward collaboration between treatment and recovery service providers. More broadly, efforts to create dialogue, collaboration, and knowledge-sharing among the many organizations and interest groups working in the SUD space (e.g. statewide workshops, conferences, and summits) will further the health and wellbeing goals of IDPH.

Policy Recommendation

Establish a funding model to support the core operations of recovery community centers. Making funding available during the start-up period substantially improves the success chances of new organizations.

- *Market recovery to communities.* Every RCC leader we spoke with stressed the importance of early and ongoing outreach to the wider community. This kind of outreach can help the RCC avoid a "not in my backyard" reaction from community stakeholders, and establish a strong and trusted foothold within the local recovery community and the wider community. Building alliances, collaborations, and connections to many organizations and leaders in the local community are critical to the success of the RCC.

- *Pay recovery staff.* Volunteers are an important part of the recovery community, but core paid staff is necessary for an efficient and effective RCC. According to many of the recovery leaders whom we interviewed, relying on a completely volunteer workforce leads to disorganization and more problems. Paid staff can be held accountable in ways that are simply not possible with a volunteer staff. Additionally, paying staff reduces the likelihood that RCCs themselves become a contributing factor to the economic vulnerability of the people in recovery who run their day-to-day operations.

  While we heard consistent support for the voluntarist model of the RCC, including its virtues in bringing many hands to bear of community development and outreach, there was clear agreement that having a small cadre of paid RCC workers was important to success, and stability of the center. The paid positions were often-times framed as a way for volunteers to work up through the organization, gaining experience, responsibilities, and, depending on the position, a paycheck.

- *Curb certifications*. Certifications for peer support specialists or recovery coaches are a positive and important part of the recovery world. They empower individuals with credentials and lend credibility and legitimacy to recovery organizations. However, over-certification can become an issue if coaches spend too much time in professional development relative to working face-to-face with the recovery population. Additionally, certification needs to make sure the person is effective as a support to people in recovery, not just a good test-taker. And further, each new certification represents a significant barrier to entry. Until Iowa has a baseline network of RCCs, and easing of barriers to entry is advisable.

- *Allow for a holistic funding model.* The overwhelming consensus among RCC leaders is that fee-for-service funding structures inhibit a holistic, personalized approach to recovery. One RCC leader suggested a good analogy for thinking about fee-for-service models: "I think fee for service is a dangerous road to follow. [It's like] daycare versus babysitting. A babysitter gets paid when they show up and watch the kids for 4 hours. A daycare says, we charge $800 a month and you get to put your kid in daycare every day. [You're] going on vacation, you still pay. RCCs operate more like a daycare: we're holding a space for your people, we can't say my person only showed up twice this month, no, we kept this place open the whole month." Issues of reimbursement and showing progress in fee-for-service models detract from the important, daily flexibility that is so vital to a successful RCC.

- *Move at the speed of trust.* The founding of a new recovery community is an exciting time filled with possibilities. As one leader put it, "Be ready to hit the ground at 100 miles-per-hour" when the organization gets started. RCOs and RCCs that do not yet have the capacity to support a large portfolio of services and activism may suffer from employee burnout and problems communicating mission to the recovery and wider communities. Instead, leaders suggest that it is wise to take time and engage with the thought and energy it takes to build a robust organization with a solid foundation. Laying out a plan, developing partnerships, and gaining trust with gatekeepers prior to the opening of a recovery community center was viewed as a critical game plan for success.

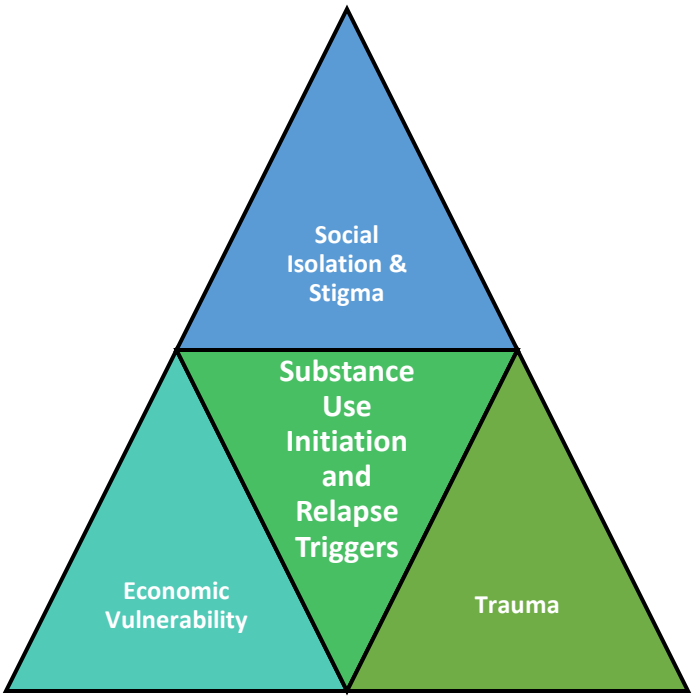
- *Be open to many different pathways to recovery.* RCCs and RCOs should have the ability and encouragement to support a variety of pathways to recovery (e.g. 12-step programming, medication assisted recovery, harm-reduction, SMART). One leader told us, "Recovery should be like a buffet. Everything should be available in portions that an individual wants and needs." Success for the recovery community rests on the ability of the RCC or RCO to open and support many individual pathways to recovery. While this approach is grounded in the ethical principles of diversity and inclusion, it rests on an important empirical principle too: Supporting a diversity of pathways to sustainable recovery appears to be an effective strategy for lower substance abuse relapse rates. RCCs that discourage all paths to recovery may end up discouraging participation in the community center.

The Need for Iowa Specific Programming

In our team's 2019 report (*Substance Use Among Iowa Families: An Intergenerational Mixed Method Approach for Informing Policy and Practice*), we identified three main drivers of substance use onset and, for those in recovery, relapse: stigma and social isolation, economic vulnerability, and trauma. We found that social isolation—being an outsider at school, work, or in the community—led many young people to engage in risky substance use behaviors. It was the desire to fit in and to be accepted by a peer group that people described as being fundamental to their own substance use story. Others spoke about how substance use cost them a job, family

relations, and more general involvement in the community. Collectively, social isolation and loneliness are deeply interwoven in the biographical narratives of people who use drugs (PWUDs) in Iowa. We also heard numerous stories that identified trauma, including both childhood and adult trauma, as being principally responsible for many relapses. The death of a loved one, the removal of a child, a bout of unemployment, and residential instability, for example, are common triggers that lead to relapse. And in the background of it all, economic insecurity is a significant risk factor. Being economically vulnerable, and especially being exposed to *chronic* economic insecurity, was a recurrent feature in the lives of many people with SUD. Owing to the importance of these factors for achieving sustained recovery, we view Recovery Community Centers as an especially high-value public health tool in Iowa. The RCC addresses social isolation and stigma by offering a sense of community to PWUDs who may not have any other meaningful social relations outside those with whom they share an active SUD. Well-designed RCCs play a critical role in connecting their members to resources that take the edge off economic vulnerability and offer a path to financial self-sufficiency. The recovery community programs and member benefits also offer myriad ways for PWUDs to manage prior trauma and proactively cope with future traumas. Recovery communities provide services, engage in advocacy, work to reduce stigma and minimize social isolation, enhancing the economic prospects of people in recovery, and mitigating the long-term effects of trauma. In short, recovery communities offer many benefits to Iowa's communities.

Figure 4. Key Triggers of Substance Use Initiation and Relapse Reported by Iowans



What types of programming should Iowa recovery communities foster and what overall goals and pathways should they promote, support, and finance? Though we differentiate between the roles of the RCC and RCO, they share many of the same goals and strategies, serve the same populations, and are guided by a similar set of assumptions that recovery should be deliberate, supported, community-based, and personalized.

In our interviews with recovery community leaders, we heard that the success of a recovery community is closely tied to the organization's ability to meaningfully address issues of isolation, trauma, vulnerability, and stigma by relying on a range of approaches. This is because recovery communities are comprised of members with very different cultural, economic, and social backgrounds. For some, faith-based programming is critical to their long-term recovery journey. For others, medication assisted treatment is critically important, especially when opioid use featured prominently in their SUD diagnosis. This is why it is important to address these issues holistically, with attention to meeting people where they are in their recovery on any given day. One leader shared a question that recovery coaches at his center ask to each new or potential member of the recovery community: "*How can we help you with your recovery today?"* We recommend considering this question in terms of stigma and social isolation, economic vulnerability, and personal traumas.

Reducing Stigma

- *Language:* Many of the recovery community leaders we talked to discussed the importance of using destigmatizing language, and greater attention to language and words more generally. There was a surprising lack of agreement about the right language to describe those who fill formal RCC support roles in the organization (peer advocates? per-to-peer mentors? recovery coaches?) but overall the language used in recovery communities was clearly *intentional* and *uniform*. The dissemination of 'recovery language,' including the importance of learning and practicing this language, was often viewed as a foundational part of the advocacy work of a recovery organization. Changing the way we talk about SUD effects changes in how we treat people with SUD, which in turn holds the potential to improve recovery prospects for many people.

- *Outreach:* A large part of what an RCO—and some RCCs—does, according to our experts, is outreach to the recovery community and to the wider community. Making recovery visible, our respondents argued, serves to destigmatize it, both for people who use substances and for people who are afraid of PWUDs. Outreach often took the form of meeting with local providers and community groups, having "SWAG" with basic contact information for the RCO/RCC printed on it, and being a good neighbor in the community. One leader described how her facility had partnered with the city to provide a municipal warming center during cold months, a role that was extra-curricular to its recovery services. Another talked about the active role her RCC took in community events such as parades and farmers markets, where they made sure that the RCC had a formal and visible presence. Being a good neighbor—actively and often—is an important part of being accepted as one by the wider community. Being a visible and good neighbor helps to reduced stigma by providing the community with positive SUD recovery role models.

- *Education*: Like outreach, education is a big part of the call of an RCO/RCC and a defining feature of its relationship to both the recovery community and the wider community. Education can take many forms, from community seminars, to storytelling from people in recovery, to "recovery walks" during Recovery Week. Getting the message out about what exactly recovery is, what it isn't (treatment or correction), and how it can help an individual and the community is a large part of what RCCs/RCOs do to reduce stigma. Correcting misperceptions, challenging outdated stereotypes, and dispelling myths is an important part of the education mission of the recovery community. Equally important, however, is the education programming that recovery communities provide to their members: Where to find child care. Which local employers will hire someone with a drug-related felony record. How to apply for housing assistance. When and where to attend mutual aid meetings. These and many other everyday topics of concern feature heavily in the education and outreach activities or the RCC.

- *Hiring*: Recovery communities are, almost unanimously, in favor of hiring people with lived experience of substance use. This in itself reduces stigma and isolation. Finding meaningful work for people in recovery, including both paid and volunteer opportunities, meets more than the economic and social needs of the recovery community. Contributing to something larger than themselves provides people in recovery with a sense of purpose and meaning which has been shown to have powerful, positive effects on mental and physical health, motivation, and emotional resilience. While we agree with the principle of recruiting people with lived experience, in practice, we advocate for a more expansive approach that also encourages the active participation and support of the SUD ally community.

Recovery Tip: Positive Images Reduce Stigma

De-stigmatization is critical for building a supportive culture of recovery in Iowa. One of the primary drivers of SUD stigma is the association between substance use and poverty, criminal behavior, and unsanitary conditions, in the minds of many people. Breaking these negative associations by linking SUD to more balanced and accurate depictions of SUD should be an essential element of de-stigmatization efforts. Toward this end, we collected images of many of the Recovery Centers that participated in our study. All images were publicly available and featured on the websites of participating recovery community organization webpages or in Google street view images. Images such as these can be used by IDPH to mitigate stakeholder bias through individuation and counter-image stereotyping techniques (see Dorius, 2020; Stonewall, Dorneich, Rongerude & Dorius, 2018).

Reducing Social Isolation

- *Location of RCC*: The location of an RCC is important in reducing social isolation for those in recovery. Having a location that is both visible and easily accessed by foot, bike, car, bus, or other form of public transportation is critically important. Finding real-estate on main street or central thoroughfares was frequently recommended as the ideal site for an RCC, as this would ensure easy access and allow the RCC to feature prominently alongside other respectable community businesses and non-profits in town. A storefront approach, rather than a 'back-alley' or 'under-the-bridge' approach, helps to communicate to the recovery community that they are valued members of the larger community. The storefront model also encourages active substance users to "come out of the shadows" and seek treatment.

- *Physical meeting and gathering space*: Many of our respondents spoke about the importance of the physical space—the center in which many community activities take place—that provides a free and open place for people in recovery to gather and problem-solve. Because we could not physically visit RCC locations, we had our respondents describe the physical layout of their centers. We learned there is often a conference room and lounge-area. Many RCC leaders talked about having free coffee and a comfortable couch so people in recovery had somewhere to go other than a place that might be associated with substance use; one leader discussed how the "free coffee" in his center was now available to "core members" (those who had been coming to the recovery community for a certain period of time and had committed to remaining sober) from 6 in the morning until 12 midnight. The important point here is to make it more social, less clinical, so it puts off a "a feeling [like] when you hang out with your friends." Although the meeting area is necessary for group sessions and partner-organization meetings (like AA and NA), the informal gathering space allows a physical location where people can come and *be* together.

- *Engaging families*: RCC leaders discussed engaging families as a best practice that they were either proudly practicing or at least actively seeking to practice. People who use drugs often become isolated from their families, and families often feel isolated from their loved ones with active SUD. Offering formal events (i.e. family bingo night) was one way that RCCs tried to bring families together. Other RCCs used a more clinical model and facilitated family therapy sessions through their "concierge" services and using an outside therapist. The openness of the RCC model that asks "How can we help you in your recovery today?" must allow for the purposeful redevelopment of family ties as part of that recovery.

- *Providing substance-free social events*: Recovery leaders told us that some the social aspects of the RCC provided a critical, essentially clinical task. They help people in recovery to have positive social interactions that do not involve substance use. For many people who have history of substance use, socializing, laughing, and having a good time came to be primarily associated with substance use. Breaking this association is one of the ways that RCCs can reduce isolation. Having an active calendar of purely (substance-free) social time for people in recovery is second way that RCCs reduce isolation.

Reducing Economic Vulnerability

- *Meeting small material needs*: RCC leaders discussed how, as part of their peer coaching process, they often had on-hand small material things that people in recovery often need: bus passes, vouchers to a second-hand clothing store, vouchers to a grocery store, or even petty cash to pay a long overdue electric or gas bills. This model affords members with a small but immediate infusion of financial aid that may stave off a harmful triggering events such as eviction. This approach also had the benefit of meeting a members' recovery needs on that particular day.

- *Job search assistance and infrastructure*: According to our interviews, recovery coaches often assist people in recovery with job searches or resumes, allowing them to reorient to paid employment. The RCC itself can provide the job search infrastructure, including access to computers and the internet, to people in recovery. Connecting community members to employment support programs, guidance on college enrollment or apprenticeship programs, and a list of employers that will hire a former felon and are some of the many offerings around jobs and employment in a typical RCC.

- *Connections to opportunities and social capital*: RCCs are often a hub of once-lost social capital for people in recovery. Through their networks, they often have a larger number of people who know of job opportunities in the area. Additionally, as we see with many people in leadership positions in the recovery community, RCCs can offer internships and recovery coaching opportunities to people who once came through their doors in need of recovery help. As RCCs look to hire people in recovery, they are able to provide these professional connections.

Reducing Trauma

- *Heading off* trauma: We heard from several RCC leaders that addressing the immediate material needs of people in recovery was often done to keep members from experiencing new trauma. Once she was fed, or his kids had heat, the recovery process could progress. Additionally, leaders talked about the importance of putting safeguards in place so that employees of RCCs who had a history of substance use did not experience secondary trauma through their work with the recovery community. Putting in place regular checks, mental health supports, and heading off burnout were some ways RCCs accomplished this.

- *Addressing past trauma*: The RCC approach to recovery is holistic and looks at "all pathways" according to many of our respondents. One respondent likened recovery to "physical therapy": it comes after treatment or surgery and has to be practiced regularly to work. Mental health services are often part of this holistic approach to recovery, and it is here that people in recovery are most likely to productively address past trauma. Whereas in the past these experiences might provoke a relapse, access to clinical health care, a recovery coach, and a supportive community facilitated by the RCC helps people deal with hardship in new, healthy ways.

What's the difference between an RCO and an RCC?

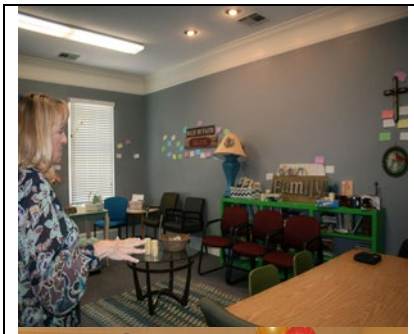
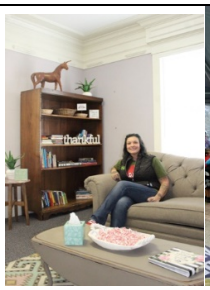
Although often used interchangeably in the text, there are important difference between a Recovery Community Organization (RCO) and a Recovery Community Center (RCC). Several of the recovery community leaders we talked to spoke about the distinction between an RCO and RCC as being similar to the distinction between a body and a soul. Whereas an RCO is the place where decisions are made, advocacy is enacted, and ideas come from, the RCC is a physical place where recovery services can be delivered by people *connected with* the RCO. Some organizations were both an RCO and an RCC; others reported to, coordinated with, or were a member of, a statewide RCO. Some states have multiple RCOs, and some have a single, centralized RCO that provides "infrastructure, expertise, and funding," as one of our respondents described it.

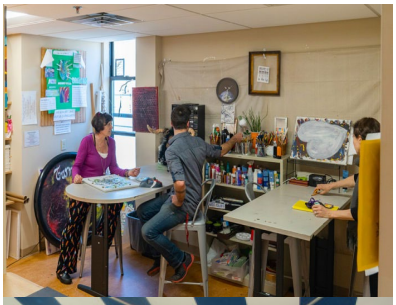
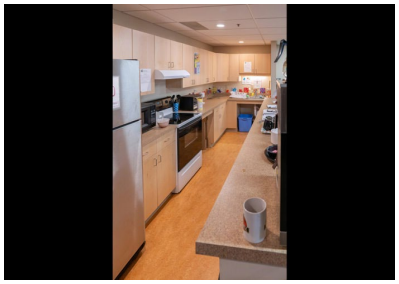
One distinct and necessary feature of an RCC is that it must have a *physical location* (see below for more information regarding the where and why of Recovery Community Center locations). An RCO, on the other hand, does not necessarily welcome daily visitors and thus may be more "virtual." To borrow from a computing analogy, the RCO is the metaphoric 'cloud' that serves as a central repository of recovery knowledge and the RCC is the local computer and hard drive that processes information received from the RCO. See Figure 5 for example.

Almost all recovery community leaders with whom we spoke described RCOs as the information and financial hub and the RCC as the physical location of services. There was broad agreement that RCOs do not require a physical location, though many do occupy a physical space. Indeed, during the period in which we conducted our interviews, all of which were done virtually due to COVID-19 travel restrictions, participants in our study suggested that RCOs could function just as effectively virtually, whereas RCCs had made courageous and intense changes to deliver services to their communities in a virtual world. Thus, the location of the Recovery Community Organization is far less consequential than the location of a Recovery Community Center. Some RCO's had office space within an RCC they supported; others were centrally based in a capital or otherwise important city in the state. Overall, an RCO must be strategically positioned to provide services to partner RCCs and to do fundraising and advocacy work in the local environment.

Photo: Dubuque, Iowa

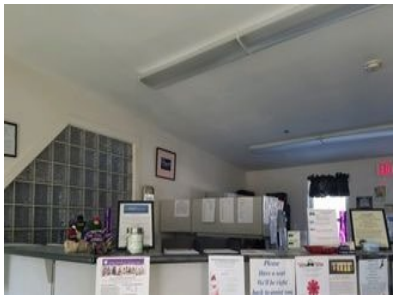
Images of Recovery Centers in Our Sample: Interior Spaces





Thank you, to each of the 28 RCC/RCO leaders from 24 states who participated in our study!

Images of Recovery Centers in Our Sample: Exterior Spaces

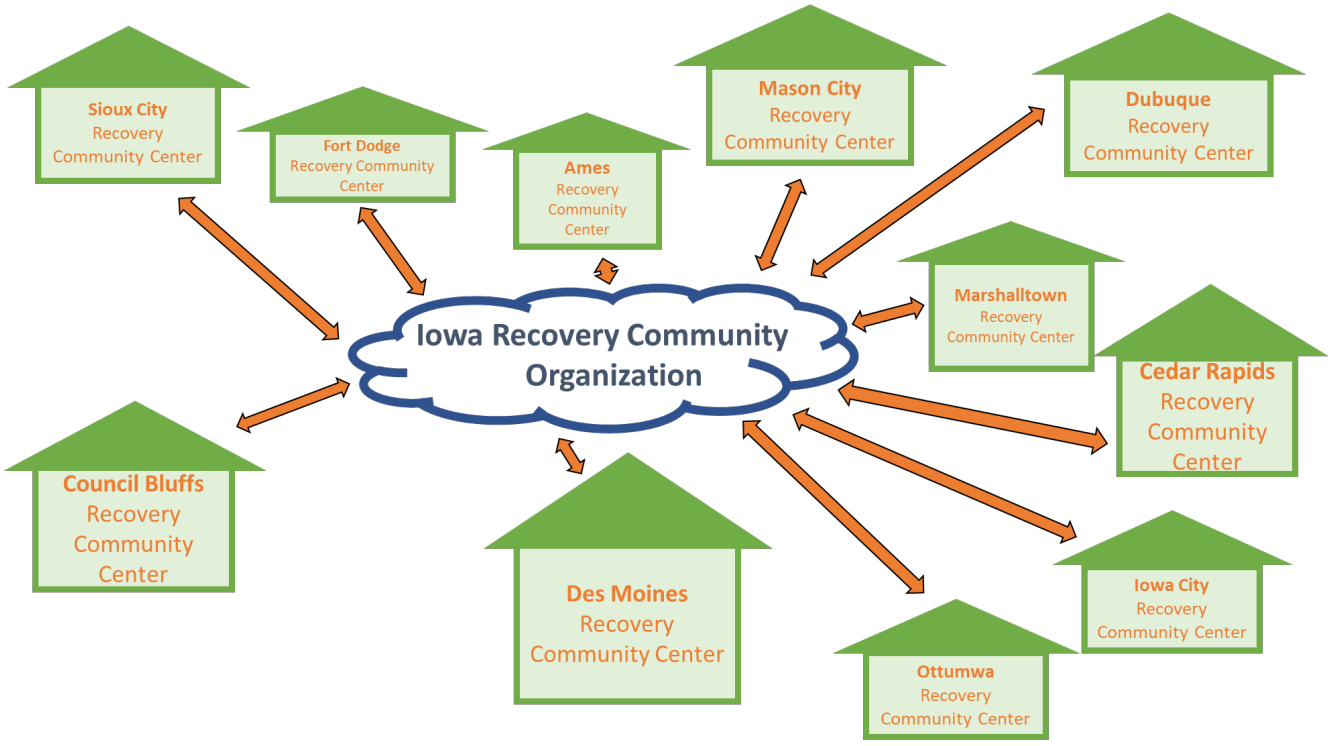
Where to Build RCCs In Iowa?

At present, Iowa does not have a Recovery Community Center (RCC) network, but IDPH is interested in supporting the people and groups working in the recovery space to facilitate the development of a network in the state. The fundamental question, then, is where to target resources for RCC development in Iowa? In our interview with a member of the leadership team at the national recovery organization "Faces and Voices of Recovery," we heard that the ideal way to begin RCC development is to complete a community assessment that helps answer the questions, *"What is out there [in terms of care infrastructure]? What do they know and who do they know?"*

Unfortunately, this is not the way these decisions are usually made. In fact, none of the RCC leaders we spoke with had selected the location for their RCCs based on community assets needed for building a successful model of recovery. Public health officials and community leaders understand that each community is different, and every time a new RCC is created, it needs to accommodate the community's unique assets, culture, and recovery

community needs. The data obtained in our interviews and reinforced by the scientific literature make clear that multiple pathways to recovery is critical to successful, sustainable recovery. The reason is because the recovery process is a personal journey, inextricably interwoven with a person's own, unique biography. This is where access to resources factors in. Places with a wealth of recovery support resources are best positioned to serve the diverse and unique needs of their recovery population. Put differently, RCCs in resource rich communities can better serve their members through their access to a wide variety of resources. This ensures that each RCC member has the particular resources they need, when they need them, as they progress through their personal recovery journey. As one of our respondents said, RCC's are a "broker for recovery," and thus need resources to broker. Establishing RCCs within communities that enjoy a wide range of local resources are able to ensure the outreach, support, and advocacy work of the RCC is well-integrated into the community. Many RCC-based respondents we spoke to talked about active partnerships with hospitals, care centers, churches, libraries, and even jails. Because of this, RCCs thrive when they are located near a robust systems of care infrastructure. If these systems of care infrastructure are lacking in a community that is interested in hosting an RCC, the basic infrastructure of the community should be easily accessible (transportation, public services, and community hubs).

Figure 5. Conceptual Overview of the Iowa Recovery Community Network



The location of the recovery center can have important consequences for social isolation. Having a location that is easily accessible by many different kinds of people, including those with private transportation and those who use public transportation, and also in a place that is easily seen by many people—like a storefront—is a best practice. An RCC "storefront" presence helps reduce stigma and provides opportunities for new partnerships. As one RCC director told us, "The Recovery Community Center needs to bring recovery out of the church basement and onto main street." This aligns with a theme we heard from many of our respondents: a Recovery Community Organization or a Recovery Community Center often aims to make recovery visible, not anonymous. The location of an RCC can underline that shift. This is a fundamentally different approach to recovery than what has been advocated by the many peer support organizations operating under the anonymous moniker. As such, it is

important the local RCC leadership seek partnerships with local 12-step organizations that focus on their shared interests and goals.

Our interview with the leadership of a collegiate recovery center reiterated this idea of close visibility. For the first few years of their existence, this CRC was located in the basement of the student union on campus. When space became available, they were able to move to the more visible fourth floor; this has been associated with greater traffic into their center and enabled them to serve a larger number of students interested in their peer-to-peer services. Another respondent discussed the importance of "walk-ins" for reaching more people in need of their services, which also highlights the importance of RCC location.

Respondents told us that RCCs should be located near public transportation for two main reasons. The first is that people in recovery can more easily visit the RCC if they have transportation options beyond just a car. The second it that people in recovery can more easily access other resources (like jobs and family) from the RCC with an easy bus ride. Again, the idea of "brokering resources" is very much place-based, and the broker needs to be in the middle of it all. Being located near a transportation hub such as a bus depot, train station, or prominent line of transportation is desirable.

We recommend continuing to find that energy amidst the recovery community in Iowa, and placing RCCs in communities that have access to the amenities listed above. However, people depending on a recovery community that lacks a strong infrastructure of care, community of recovery, transportation, or storefront visibility still need support. One way to continue to build these supports is to engage with resource-deprived locations to see what types of recovery services make sense for their communities. Our experts on recovery communities suggested that a motivated group of individuals can and will make any place work with best practices of advocacy and care, assuming they have the right leaders. Overall, we heard the refrain that the right place looks different according to the needs of the local community.

Who Should Lead RCCs in Iowa?

After the first several interviews we conducted, an important theme became very clear: the right leader is as important as the right funding or right location for the birth of a recovery network. We thus added a question to our protocol that asked every respondent how they thought we should go about finding the right leader for Iowa. We also analyzed the backgrounds and personal stories of the people we interviewed to assess qualities of successful recovery community leaders.

Though some of the most successful leaders amongst our respondents do not have personal experience with substance use, they all had some kind of "golden combination" of passion and professional skills, such as fund raising, office management, human relations, or clinical health. Our respondents described these coinciding qualities in various ways: "skill and perspective"; "intellect and passion"; "anti-oppression oriented with basic skills." Overall, however, our respondents agreed that the right person to lead recovery community is someone "that has had the trajectory of their life changed by the recovery community," whether that community saved their physical lives or provided them a true passion for which they can use their leadership skills. One of the most impressive RCC directors with whom we spoke became involved in SUD recovery after losing a son to substance abuse, but had no personal use history.

Our respondents also described the right leader as having grit and perseverance to overcome the almost certain obstacles they and their organizations will face, especially in the founding weeks, months, and years. As one

respondent said, “It’s important to have someone who knows the storms that recovery brings [so they] don’t give up.” Having someone familiar with the community and who possesses strong local connections and/or the ability to build social capital within the community was also a point of agreement for most of our respondents. Recovery is local; leadership should also be local. Personal connections, local knowledge, and community legitimacy should drive this local orientation.

All of our interviews began with the basic question, “Tell me about yourself. How did you come to work at [RCC/RCO name]?” The answers to these questions allowed us to identify several major patterns in the professional and personal lives of recovery community leaders. Many had business backgrounds or had developed business skills through years of work within an RCO or RCC; often, our respondents were also themselves in long-term recovery.

Recovery Community Leader Personas

Based on our analysis of responses to the work and life histories of our interview participants, we developed three Recovery Community Leader Personas to support RCC leadership recruitment in Iowa. Although these personas are hypothetical archetypes and do not reflect the experiences of any one person, they do reflect the common experiences and characteristics of actual recovery community leaders with whom spoke. For example, several personal biographies described a person with a strong background in non-profit leadership who came to work at an RCC through their own experience with substance use.

1. *Person in long-term recovery turned recovery specialist*

Many of the executive directors, board members, and higher-level officials in RCCs/RCOs that we interviewed fit this persona. These respondents were often older and further along in their careers and most had a history of substance use that had either interrupted their previous career or marked its trajectory. For example, one executive director discussed how she had always wanted to work in corrections, so she got her degree in social work. Owing to her personal history of substance use, she was legally forbidden to work in her preferred field. Instead, she worked her way up to an entrepreneurial job starting recovery residences. Another who fit the persona of former substance-user-turned-recovery-specialist views recovery centers as an important step toward sustainable, long-term recovery. This view arises from her lived experience, which included internship and volunteer work with recovery communities that allowed her to gain valuable professional experience and steadily work her way up through the organization. The interest in recovery as a profession grew with her lived experience with recovery. These leaders’ extensive experience in the field (and in many levels of the organization) provide rich and rewarding professionalization concerning the important business aspects of RCO and RCC management.

2. *Values-Based Nonprofit Leader*

Some of the most successful RCC leaders have a passion for recovery that is purely—but powerfully—professional. These leaders often hold degrees in mental health counseling, social justice, public policy, or nonprofit management and have identified important gaps to fill in recovery services and outreach. They have extensive experience searching for, writing, and receiving grants, something frequently conveyed to us as an essential skill for a successful member of a recovery community leadership team. Although this type of leader may not have first-hand experience with SUD, or even second-hand experience such as a family member with SUD, they are passionate about the work and shrewd in how to manage the business and financial aspects of an RCC or RCO. For example, one respondent we talked to was a substance use disorder specialist with a long professional history of work as a counselor and advocate. Following a move to a new community, this person observed a gap between SUD treatment and the rest of a person’s life, which motived them to get involved in the local recovery community

center. This person is now chairman of the board of directors for the local RCC. Another leader talked about getting their Master of Arts degree in Education while living in the community, and when an opening came to make a difference in the local RCC, she took the program manager job there, where she is actively engaged and helping to lead a vibrant RCC.

3. *Converts after Crisis*

The executive director of a small-town RCC told us the story of how she became involved in the recovery community movement. She was nearing completion of her college degree when she got a call from the hospital: her son, who had a history of substance use, had tried to commit suicide. While she was trying to figure out a way to best support her son, she discovered the local recovery community and started volunteering there—five years later, she is leading the local RCC. Like this executive director, "converts" describe a major event or moment in their own substance use experience—or, with several, the substance use of close family members—that made them rethink their career direction and gave them the impetus to start and/or lead an RCC. Often, this change in direction is sudden and these types of individuals can point to the discrete event that made them rethink their career. These particular leaders bring a lot of passion to the work and have the key ingredient of first-hand experience. They usually acquire many of the key business aspects of running an RCC "on-the-job". This learn-by-doing model was common and suggests that prior work history is not the only criteria that should be considered when recruiting for positions in an RCC. Many future leaders that fit this persona were either profoundly affected by family member's personal experience with SUD or were younger and rising up through the organization with the aspiration to eventually become a "long-term recovery" type of leader.

Resources to Support RCC/RCO Development

In the section that follows, we overview the type and quantity of resources provided by the leaders we interviewed. These are organized into five categories to support aspiring recovery leaders by connecting them to much of the foundational information necessary to successfully build an RCO/RCC network in Iowa.

- *Funding*. Information related to obtaining funds, budgeting, or allocating funds.
- *Governance*. Resources related to the functional aspects of building an RCO/RCO business, such as bylaws, structural information, planning, and fundamental information necessary for building, sustaining, and improving a recovery facility.
- *Standards*. These resources relate to the expectations that RCO's/RCC's uphold for themselves, their employees, and/or their clients.
- *Tools and Resources*. This includes general information related to RCO's and RCC's, how they can be distinguished from one another and treatment centers, and other details.
- *Outreach*. These resources relate to community outreach and tips for building relationships with a variety of community stakeholders.
- *Toolkit*. Several RCO/RCC directors that we interviewed had developed their own 'toolkit' that they shared with us and that are captured here.

Table 1. Recommended Resources to Support Recovery Community Organizations.

Recovery Community Organizations	
RCO: TOOLS AND RESOURCES	
State, Organization Name, Website	File Name, File Date, Description
Idaho Recovery Idaho https://www.recoveryidaho.org/	*RCO_FinalLaunchReport, 2014* Final report for the launch of Recovery Idaho (lessons learned, overview, plan, moving forward, etc.)
Iowa Iowa Department of Public Health (IDPH) https://idph.iowa.gov/	*IDPH_RCOInformation, 2016* Information provided by IDPH that talks about what and RCO/RCC is and how you can learn more.
New Mexico Recovery Friendly New Mexico http://rfnm.org/	*RCO_TaosToolkit, NA* Planning toolkit that covers mission, values, goals, timeline, budget, community development, timelines, significant data, and related news.
NA Faces and Voices of Recovery https://facesandvoicesofrecovery.org/	*RCO_Toolkit, 2012* Includes tools for strategies, principles, examples, advocacy work, local RCO's, keys to success, tips, etc. *RCO_Definition, 2007* Leaders in the recovery community created this clear definition to help show others what an RCO is.
RCO: GOVERNANCE	
State, Organization Name, Website	File Name, File Date, Description
Florida Recovery Oriented System of Care (ROSC) https://www.myflfamilies.com	*RCO_SystemicTransformation, NA* Systemic transformation over the last five years of recovery in Florida.
Vermont Vermont Recovery Network https://www.vtrecoverynetwork.org/	*RCO_RecoveryServiceStandards, 2017* An outline for what is expected of staff in their quality of service, including operation, organization, standard, and self-correction.
RCO: STANDARDS	
State, Organization Name, Website	File Name, File Date, Description

Florida The Florida Department of Children and Families, Office of Substance Abuse and Mental Health https://www.myflfamilies.com/service-programs/samh/	*RCO_RecoveryBlueprint, 2020* A blueprint for recovery-oriented services and working to improve the quality of the services provided.
RCO: OUTREACH	
State, Organization Name, Website	File Name, File Date, Description
Idaho The Center for Hope https://www.centerforhopeif.org	*RCO_AdvocacyInformation, 2019* VOICE Advocacy events information.
New Mexico Recovery Friendly New Mexico http://rfnm.org/	*RCO_Summit, 2018* Report of substance-use summit from Recovery Friendly New Mexico. Discusses Taos County's continuum of care, public forum discussions, and booth participants. *RCO_RecoveryMonthToolkit, 2015* An introduction to recovery month as well as a plan for events, goals, media, materials needed, fundraising tips, evaluation, and information about RCO's. *RCO_TaosSummitReport, 2012* An introduction of the summit and detailed information related to planning, goals, the day of the summit, and some ideas on what they should do next.
New Mexico Alcoholism Treatment Program https://riograndeatp.org	*RCO_CommunitySummit, NA* An outline for the community summit that has a timeline, goals, objectives, and a description of the summit.

Table 2. Recommended Resources to Support Recovery Community Organizations.

Recovery Community Centers	
RCC: TOOLS AND RESOURCES	
State, Organization Name, Website	File Name, File Date, Description
Connecticut Connecticut Community for Addiction and Recovery (CCAR) https://ccar.us/	*RCC_AnnualReport, 2019* A recent update on the year they have with quantitative and qualitative information relating to their RCC. They also have included information such as their values, mission, their story, board members, advocacy work, services, training, administration, and revenue/expenses. *RCC_Standards, NA* Information about core elements of an RCC including general principles and guidelines, specifying what an RCC is not, information about the site/location, administration information, programming, volunteers, and technology.
RCC: GOVERNANCE	
State, Organization Name, Website	File Name, File Date, Description
Connecticut Connecticut Community for Addiction and Recovery (CCAR) https://ccar.us/	*RCC_AntiRacialStatement, NA* Action items and a promise to promote equality and end racism. *RCC_Bylaws, 2005* Bylaws that support CCAR's mission and vision. *RCC_OrgChart, NA* CCAR's organizational chart. *RCC_StrategicPlan, 2020* CCAR's plan to enhance their Board of Directors, advocacy work, services, training, and administration while also stating their mission and values.
Idaho Idaho Association of Recovery Community Centers (IARCC) https://www.idahorccs.com/	*RCC_IdahoBylaws, 2019* IARCC's bylaws for their facilities. This includes information related to the purpose, membership, funding, resignation, meetings, officers, elections, and amendments.
North Carolina Recovery Community of Durham (RCOD) https://www.recoverycommunityofdurham.org/	*RCC_DurhamBylaws* Bylaws for RCOD (purpose, vision, mission statement, membership, annual meeting, Board of Directors, officers, committees, amendments, and miscellaneous.)
RCC: STANDARDS	
State, Organization Name, Website	File Name, File Date, Description
Idaho Idaho Association of Recovery Community Centers (IARCC) https://www.idahorccs.com/	*RCC_IdahoStandards, 2019* Idaho's operating principles and standards such as the purpose of an RCC, roles, administration, programming, volunteers, general information, compassion, acceptance, and other foundational principles.

Table 3. Recommended Resources to Support Other Recovery Related Organizations.

NATIONAL GROUPS	
OTHER: FUNDING	
State, Organization Name, Website	File Name, File Date, Description
National Substance Abuse and Mental Health Services Association (SAMHSA) https://www.samhsa.gov/	*SAMHSA_GrantInformation, NA* Information related to a grant that was available in 2014 through SAMHSA for recovery community services.
OTHER: TOOLS AND RESOURCES	
State, Organization Name, Website	File Name, File Date, Description
National International Certification & Reciprocity Consortium (IC&RC)	*ICRC_BoardDirectory, NA* This is a map with the states/countries who are members and adhere to IC&RC standards.
National Substance Abuse and Mental Health Services Association (SAMHSA) https://www.samhsa.gov/	*SAMHSA_RecoveryResource, NA* SAMHSA recovery resources and information to access social support groups as well as hotlines.

COVID-19 Programming

We began interviewing many of our respondents right around the time that the United States was shutting down because of the emerging threat posed by COVID-19. Indeed, our first interviews took place over the phone with RCC leaders in Idaho the last week in February. We had to cancel our planned trip to Connecticut the third week in March because of COVID-19 travel restrictions. As a research team, we adapted to the new format of Zoom interviews, phone calls, and internet research. Our adaptations were minor, however, compared to some of those that our respondents were experiencing.

An RCC-based recovery network is, as our data above show, a very place-based and physical experience. RCCs represent the literal location at which recovery support and many services are provided; our respondents told us how they had gone to great lengths to secure physical locations to provide the most access to the most people. When the pandemic started to affect daily life, RCCs shut down in states that had stay-at-home orders, and even closed their physical doors in other states that had less stringent orders, but rising case numbers. This affected all of our respondents—when we asked them what services their RCC provided, we often heard a variation of the following: "Well, *before* all of this started it was one thing, but now…" During the time we were interviewing, the world's operations—and those of RCCs and RCOs—were changing rapidly.

Our respondents and their teams adjusted themselves and their services with amazing speed and ingenuity. Support groups went online. When social distancing outside became known widely as a safe option for meetings, porches and backyards of the RCCs themselves were utilized in ways that their lounges and couches had previously been used. Some employees moved away to be with family but still logged in every day to pursue the RCCs mission

through the magic of Zoom, Microsoft Teams or any number of other video-based meeting platforms. In fact, one RCC leader told us that Zoom had allowed their organization to offer more meetings at a greater variety of times, and that some people they hadn't seen in years—due to transportation issues or problems with social anxiety—were logging in and joining the recovery community once again. A leader of a different center told us that putting people in touch with a variety of support services was possible through Zoom in ways that had been more onerous in person. Based on these accounts, **we suggest that Iowa RCCs continue to offer a suite of virtual services and points of contact with the local recovery population even after COVID recedes**. Virtual meetings is another way to meet people where they are.

There were some serious setbacks due to COVID. Many leaders acknowledged they were just trying to hold on to some semblance of normal until they could convene people, physically, in person again. One leader told us that their RCC was trying to be diligent about checking up on people because of the stress and greater possibility of relapse during this unprecedented time; sometimes, they couldn't get ahold of the people who frequented the center, and there was little they could do about this with stay-at home orders in place. There was a real sense that some members of the community might not fair well in the pandemic because of less access to the center.

Overall, however, recovery leaders suggested that the pandemic-induced change to become an online community may have opened up doors they had previously not considered for peer support and recovery coaching. As the best-practice for RCCs and RCOs is to create a "buffet" of offerings, and to meet people where they are in their recovery and life, the ability to go online and have it work well enough to provide some support yet another way that RCCs and RCOs may pivot in the future.

Next Steps

Based on the feedback and advice we heard from national experts working in the recovery community space, we propose a series of 'next steps' to strengthen and expand substance use recovery efforts in Iowa. In the recommendations that follow, we propose a strategy for developing a statewide network of Recovery Community Centers.

Why:

Recovery Community Centers represent an important component of a robust public health prevention program. The prevention of relapse is a straightforward example of how recovery centers can contribute to public health prevention efforts. Finding ways to reduce the length and duration of SUD relapse events in the family context also represents a way to prevent the intergenerational transmission of SUD. Community-based SUD recovery

organizations strengthen local communities, mitigate the harms of SUD on individuals, families, and communities, and grow social capital that reconnects marginalized individuals to society.

Where:

In thinking about where to build RCCs in Iowa, we developed a method that aligns with advice we heard from a member of leadership at the national recovery community center association: "Do a community assessment. What is out there? What do they know and who do they know."

Each community is different, which means that the RCC development strategy will be a bit different in each community. We collected a large amount of community-specific data detailing the local recovery infrastructure. We used this information to create a Recovery Ready Community Index, or RRCI, that identified the top 30 recovery ready communities in Iowa. We propose that IDPH target several small, medium, and large cities from this list for further community profiling and engagement (see "The Recovery Ready Index, A Public Health Assessment Tool" for more details).

Who:

One of the most consequential decisions is who should lead RCC efforts and how they can be empowered to fulfill their role. Recovery community leaders told us that an RCC leader has to "be willing to put it all on the line for the RCC/RCO" and needs to have an "entrepreneurial spirit." This person will be both the "catalyst" and the task master. Perhaps most importantly, RCC leaders should have local buy-in, a working relationship (or ability to develop one) with key community stakeholders, and a solid understanding of how to build coalitions, solve problems, and deliver results. We have identified several potential RCC director candidates, but we advise that RCC leadership selection should emerge from the community engagement process so that the local community has adequate input and, ultimately, choice about who will lead. The non-profit sector, members of the recovery community, and community-embedded clinical professionals are a natural fit for RCC leadership. For this reason, efforts should be made to engage with these groups in target communities. One RCC leader suggested that we find about 30 Iowans "fired up" about recovery and build recovery communities in places they best know, where they are able to best make the system work for the centers. "If you build it, they will come," he said.

Table 4. Recovery Ready Communities

First Tier	*Second Tier*	*Third Tier*
Sioux City	Atlantic	Burlington
Mason City	Carroll	Knoxville
Fort Dodge	Decorah	Charles City
Dubuque	Clinton	Winterset
Ames	Muscatine	Spirit Lake
Iowa City	Fairfield	Newton
Ottumwa	Bettendorf	Algona
Council Bluffs	Harlan	Cedar Falls
Marshalltown	Boone	Des Moines
Cedar Rapids	Spencer	Mount Pleasant

NOTES: These cities scored high on many of the four dimensions of the recovery ready community index and should be given high priority in future community engagement efforts.

How:

Based on the feedback we heard from current and former RCC leaders, we suggest that between three and six communities listed among the top 30 recovery ready communities be targeted for detailed community profiling, followed by community engagement. In the community profiling step, we suggest the production of detailed community maps that identify the local recovery infrastructure, major thoroughfares, main street, and public transportation routes. We also envision the community profiles to provide a rich description of the composition of the community, including its social, economic, demographic, and cultural characteristics, with special attention to characteristics that related to substance use recovery. This information will help the community to understand their own community assets, strengths, and need for an RCC while simultaneously communicating that IDPH

knows something about the community as well. Organizing an information session in which key community stakeholders come together (virtually or in-person) to learn about RCCs, community assets, the benefits of, and need for an RCC, and the general process of creating an RCC is one way to engage the community.

From that session, we suggest that the *Public Science Collaborative* deploy methods to hear and understand community concerns, real and perceived obstacles to RCC development, and identify stakeholders that are willing to collaborate. A second community engagement meeting developed around a Design Thinking Workshop will allow our team to work with the community to design an RCC development plan that builds on the strengths, assets, and motivations of the local community. In this session, we envision time will be devoted to hearing and addressing concerns, identifying an action plan, selecting committee members to oversee RCC development, and calendaring next steps. A number of the RCO and RCC directors we spoke with volunteered to provide Iowa support in convening a new RCO or RCC, and holding a virtual convening with burgeoning Iowa leadership and national leaders will help to strengthen our plan. Our team has created an RCC/RCO start-up toolkit and a list of contacts from national organizations that can help fledgling RCCs in Iowa to get up and running. The start-up toolkit contains sample governance documents, organization by-laws, mission statements, and other materials that can greatly simplify RCC founding.

A central question to consider in preparation for community engagement is RCC funding. Where will initial funding for RCC development come from and how will the RCC transition to self-funding? In many states, start-up funds often came from state or federal dollars earmarked for substance use treatment or prevention. The size and duration of funding varies considerably from state to state, and in every interview we conducted, participants affirmed that RCCs need to secure their own long-term funding and to do so in creative ways. The RCO was viewed as a high value mechanism to centralize and coordinate fundraising and infrastructure support across RCCs in the state. In many instances, the host community provided in-kind donations (rental space) and occasionally matching funds. Partnering with city development agencies to find short and long-term funding is a central activity of RCC development. At a minimum, successful RCCs had enough start-up funds to support a full-time staff member (e.g. an RCC director). Additional start-up funds typically cover infrastructure (rent, electric and water bills, internet connection, computers and phones, and furniture), marketing materials to aid in outreach efforts, and funds to support additional staff.

Another crucial point is whether to build RCCs within an RCO framework. Either approach can work, but when possible, it is advisable to create RCCs alongside the RCO that can support them. RCOs can lay the uniform foundation (and can help find the ongoing, local funding) for several RCCs, who will then be able to focus on their person-to-person work. RCOs can be administered virtually—and a robust RCO supports the local, people-oriented work on RCCs. Respondents told us to locate an RCO where the state money and expertise is, and have them support the on-the-ground work of RCCs. Some of the early RCC development work that can be supported by an RCO includes holding a convening of experts to identify Iowa's resources and needs, create uniform bylaws, and mission statements, for example. Several of the RCO and RCC directors we spoke with recommended inviting burgeoning Iowa leadership and national leaders to the convening to strengthen the plans developed.

When:

Community engagement should move at the speed of trust. We suggest that community engagement be targeted and timed to maximize success. COVID-19 poses a real challenge, but not an insurmountable one. Community profiling should begin soon and this effort should flow into community outreach efforts. Building local coalitions, assessing community interest, and working through community stakeholder concerns can and should run parallel to other RCC development activities.

Appendix A: Methods

Because we are interested in the population of RCCs and RCOs across the country, we began by building a registry of all known organizations. We identified 169 RCCs and 152 RCOs across 45 states and the District of Columbia. We targeted our recruitment to states that had well-known, well-established recovery networks and states that were regionally- and demographically similar to Iowa. We also focused recruitment efforts on relatively new organizations in several states, and tried to build a sample with a wide coverage of the nation.

In addition to targeting the organizations on our list of RCCs and RCOs, we also interviewed three individuals referred to us from the RCCs and RCOs that we interviewed. These 'snowball sample' interviews were with leaders in two national organizations and a leader of a state-wide initiative. These interviews gave us a better idea of the landscape of recovery communities in general, and how national organizations and state government may support and guide the development of a recovery network in Iowa.

In total, we spoke to 28 representatives from 27 organizations, in 24 states. Thirteen of our respondents were from cities with a population of more than 100,000, 10 were from cities with a population of between 25,000 and 99,999, and five were from town with a population of less than 25,000. We spoke to people from all four main regions of the United States, as defined by the Census Bureau.[2] Six hailed from the Northeast region, eight from the South, seven from the Midwest, and seven from the West. Fifteen of our respondents presented as men, and thirteen as women. Our respondents' organizational roles varied: we spoke with 10 executive directors, six directors, six managers, two presidents, two founders (one of whom was also the executive director,) one RCC chairperson of the board of directors, one statewide coordinator, and one licensed drug and alcohol counselor.

Our interview consisted of 21 open-ended, guiding questions for leaders to answer (See Appendix: RCC Interview Protocol). We began by asking leaders about their own background and how they came to work for the organization, and then asked about the history of the organization itself. Our questions covered the organization's daily work and clients, community relations, recovery structure, certification, funding, obstacles, opportunities, and at the end solicited advice for Iowa as we move forward with building a recovery network. The interviews ranged from 30 minutes to two hours long, with a modal time of about one hour.

Our original research plan emphasized going to the RCCs and RCOs to meet the leader and tour the facilities in person. Because recovery is very much a personal and place-based activity, these in-person interviews would have been extremely strong and revealing. However, due to the unprecedented events of the pandemic, our research became virtual. We ended up utilizing virtual conferencing technology as much as we could, and sometimes speaking on the phone to our respondents. We were able to still have in-depth, personal conversations with recovery leaders, and sometimes got virtual tours of the spaces before most facilities closed down in response to stay-at-home orders. There were some unexpected advantages of going online. For example, we were able to record the majority of the interviews that we did and go back and refer to the audio afterwards; if these interviews had been in-person, it might have been more awkward to record. Scheduling and rescheduling interviews proved less onerous that it could have been. Because no one was traveling across the country for these interviews, if something came up in the schedule on either end, we easily rescheduled to a time where we were more able to have an in-depth conversation with the expert. Finally, the ability to plan for future meetings will not be hindered by the cost of travel. Many of our respondents told us to stay in touch and that they would be amenable to being convened in a future, online meeting format. Finally, we were able to talk in-depth to people from a greater geographic range than we would have been able to talk to if we had physically visited for all interviews.

[2] https://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf

Appendix B: RCC Interview Protocol

Name of Team Member Completing Interview:
Date:
Name of RCC Contact:
RCC State:
In-Person/Phone:

Note to interviewer: RCC is used to designate the organization you are talking to. In Iowa, where the RCC/RCO structure is not yet set up, the organizations will not necessarily recognize the RCC/RCO language. Use your best judgment to change word usage as appropriate.

Thank you so much for agreeing to meet/talk with me today. As you know, I'm from Iowa State University and part of a team working with the State of Iowa to propose the best way to create an RCO and RCC structure for the recovery services in the state. I'm interested in learning about your work here, and getting an idea of the breadth of work you do, as well as what kind of relationships you have to other recovery services and the greater community in (City/State). I'll be taking notes as we talk, but, if it's okay with you, I'm going to record our conversation. This will help me make sure I don't miss anything important, and be able to revisit what you said when I go back to write our report. Is that okay with you?

Great. Let's get started. You're the expert here, so please let me know if I'm missing any important topic—no information is too small!

1. Tell me about yourself. How did you come to your work at [RCC Name]?

PROBE:

- Past experience
- Tenure at RCC
- Title at RCC
- Previous relationship to community/state work.

2. Tell me about [RCC name].

PROBE:

- How long has it been up and running?
- What major services do you provide?
- How many people are served?
- What does your service fee structure look like?
- What is the funding structure?
- What is the structure of the staff? Board?
- What's the trajectory of its work (growing/shrinking)?
- What national organizations is it affiliated with?
- What are its main goals?

3. I'm interested in learning a little bit about what your day-to-day work looks like here, and how all the pieces come together. Can you tell me about a typical weekday at [RCC name]?

PROBE:

- Opening hours
  - If not open 24 hour, what do you do after hours?
  - If open 24 hours, how do you maintain standards of employee and client well-being?
- Services offered (each day, weekly, on-demand, etc.)
- Number of people served each day?
- How often do people return for services?
- Where do you refer to if you cannot accept a client?

4. Tell me a little about the people you serve. Where are they from, what brings them here, etc.

5. Let's talk a little about the beginning of [RCC] name. Broadly, what you're founding story?

PROBE:

- Where did initial funding come from?
- What challenges did it face in the beginning?

6. Tell me about the relationship that [RCC name] has to the wider recovery community in [State].

PROBE:

- How are referrals made?
- What other organizations, entities, or policies do your work with closely?
- How and where do you document shared information?

7. Tell me about the relationship that [RCC name] has to the wider community in [City, State].

PROBE:

- What are the major things that affect this relationship?
- How stable is this relationship?
- Where are the greatest strengths or challenges in this relationship?

8. Some RCCs have accommodations and programs for a variety of different types of people—veterans, the LGBTQ community, people with disabilities—and some provide more of a general programming. How about for [RCC name]?

PROBE:

- How does this affect your ability to meet your organizational goals?

9. Tell me about how [RCC name] works with the families or close communities of clients who use or have used substances.

10. [For current RCCs probably under an RCO umbrella] As you see it, what is the difference between an RCO and an RCC?

PROBE:

- What is your RCC's relationship to its parent RCO?
- How do you distinguish between the work and RCO does and the work and RCC does?
- What are the differences in structure?

11. Tell me about any certifications you have here at [RCC name].

PROBE:
- Which do you see as most valuable?
- What are the differences between certifications?
- How necessary are they for the work that you do?

12. How do you coordinate with the other RCCs (or other substance use recovery organizations)?

PROBE:
- What is the model of communication?
- What works well? What could be improved?

13. We know that recovery is a life-long process, but funders often want to see results within a particular time frame. How do you communicate with your funders and other stakeholders about the successes of your RCC?

14. Tell me about the different pathways to recovery that you've worked with or learned about since your began working with [RCC name].

PROBE:
- What has been particularly successful?
- Do any particular anecdotes or cases that stick out?

15. We have heard that offering jobs and leadership positions to people with a history of substance abuse is a priority of some RCCs. How about for [RCC name]?

PROBE:
- What have been the successes of this model?
- What have been some of the challenges?

16. What setbacks have you experienced in the past [number of years RCC has been active] years?

PROBE:
- How have these setbacks affected your work and outlook at [RCO name]?

17. What would you say are the major successes at [RCC name] over the past year?

PROBE:
- How have these successes affected your work and outlook at [RCO name]?

18. What advice would you give us—and the state of Iowa generally—as we look to starting a network of Recovery Centers?

19. Is there anything else we should know that we haven't yet touched on?

20. (If you haven't already had a tour of the facility): I'd love to see the way everything is laid out here at [RCC name]. Would you be able to give me a tour?

21. How do you think we should go about finding the right RCC leader for Iowa?