YPR

Young People in Recovery

POLICY ANALYSIS

AU Graduate Student Team

Critical Policy Analysis of Young People in Recovery's (YPR) Recovery-Ready Communities: Locality Support for People with Substance Use Disorders

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EXECUTIVE SUMMARY

This is a policy analysis of Young People in Recovery's Community-ready community model. Its mission is to improve resources and support services for people with substance use disorders within their community The analysis describes the implications and effects produced by the Recovery Ready Community model becoming the federal framework for public health entities and others who work in similar domains. Recommendations are made on the potential impact on a variety of public sectors through fiscal impact statements and comparison analysis. The central focus of the policy analysis will be on five main pillars of the Recovery Ready Community Model. Those are as follows: Harm reduction, Housing, Criminal Justice & Judicial, Recovery Support, and Education.

The purpose of our analysis is to discuss the current data and research that has been conducted that can show the benefits of adapting the community-ready models for cost-effectiveness to the taxpayer. In addition, this analysis will discuss the success of people with substance use disorders to continue their path to recovery for their wellbeing. Substance use is defined by use of illegal, recreational controlled substances and alcohol. Marijuna, tobacco, and vape use is not addressed in this analysis.

Harm reduction services and programs have a documented history of being effective at reducing public health concerns and increasing safety of communities. These services include destigmatizing language when referring to individuals who have substance use disorders & those in recovery, access to naloxone, Good Samaritan laws, awareness, prevention & testing of blood borne infections like HIV & Hepatitis C, access to Syringe Exchange Programs, and Safe Consumption Facilities. Harm reduction approaches are facilitative rather than coercive and aim to reinforce positive change in a person's life.

Housing for people recovering from SUDs is vital to their ability to maintain their recovery status. Housing First seeks to provide safe, stable housing for people struggling with homelessness and other behavioral health issues. Rapid-Rehousing has shown similar results.

Substance use does not end in incarceration.The crime that led them to serve time is most likely related to their substance use disorder. Drug Court programs aim to reduce recidivism rates, reduced substance use among participants and rehabilitation of people in recovery. Not all people convicted of a drug related crime are selected for drug court. There is a disproportionate impact on black and brown people in the screening, evaluation, diagnosis and treatment of people with mental health problems, including substance use disorders. The success of the program is critically dependent on the nature of the offender's interaction with law enforcement and the supportive environment. This is a public health problem not a criminal issue. Since current studies are not readily available to provide data-driven proof of successful performance of the programs, more research is needed to make accurate and transparent conclusions.

Support during and post-treatment is echoed in fostering collaborations and partnerships with drug courts, public agencies, and community‐based organizations to create local support and enhance drug court program effectiveness and advocacy. Reframing the language around the topic of addiction is important. Emphasizing "person-first" language can automatically fight thoughts or beliefs which speak from a model of deficit to one that recognizes both vulnerabilities and strengths, but does not disparage shortcomings. Recovery support is vital for growing or maintaining a person's recovery capital. Recovery-oriented systems of care attempt to link the different aspects of the recovery process in a network that supports individuals on a holistic level. Effective recovery-oriented systems will touch upon each pillar in a recovery ready community.

Finally, the question of which type of institution best supports a person recovering from a SUD as they aspire to earn a high school or college degree is examined. Recovery High Schools and Collegiate Recovery Communities seek to build a student's recovery capital by offering these students specialized supports as they make academic progress. Students in recovery are a population of special needs students who are often overlooked for built-in supports in an environment that is almost hostile towards the status of their recovery. For academic communities to be truly inclusive, they need to take better consideration of the needs of these students.

We hope that at the conclusion of this analysis, stakeholders will take heed of our recommendations and answer the call to provide more funding for research on best practices and other programs relevant to this cause.

BACKGROUND

Far too many communities are lacking available and effective resources and education to help and support people with substance abuse disorders. This often leads to relapses, accidental overdoses, potential public health issues, increased incarceration rates and the ongoing drug epidemics.

Introduction: RRC Model & Pillars

Young People in Recovery's (YPR) mission is to provide life skills and peer supports to help people recover from substance use disorders and to reach their full potential. YPR envisions a world where all young people have the resources they need to thrive in recovery from addiction to drugs and alcohol. As such, Young People in Recovery works to make communities become recovery-ready. They have created a blueprint that they suggest will help to change the trajectory of the Substance Use Disorder crisis in the United States. This blueprint is called, The Recovery Ready Community Model[1]. It lists eight different pillars (areas) that suggest a community would need in order for it to provide its community members with the maximum potential of a person to find and foster recovery, as well as the community to be an ecosystem that enables the health and protective factors of all community members. Those pillars include: Prevention, Treatment, Harm Reduction, Judicial & Law Enforcement, Housing, Education, Employment, and Recovery Support.

This analysis will look at four of the eight pillars that Young People in Recovery has identified as key areas of policy development in the 2021 landscape. The five areas that will be discussed in this paper are Harm Reduction, Housing, Criminal Justice & Judicial, Recovery Support, and Education. This analysis will look at historical and current data (where applicable), programs that are subsets of the pillars, and policy measures that enable the desired outcomes.

[1] (Young People in Recovery, 2020)

Young People in Recovery: A review of the Data

YPR has two different branches of the organization that offers recovery support services. One branch is their program department and the other is the chapter department. The program department is a more structured program setting that leverages partnership in communities to offer a life skills curriculum. This program is embedded into established treatment centers, recovery community organizations, and other peer support agencies. The **Figures 1-9** highlight the persons that YPR interacted with as a result of these partnerships. The chapter department is of a different variety than that of the program department. The chapter department interacts with people from communities at large. This could be in the form of participating in events hosted by local chapters, like All-Recovery Meetings, Pro-social events, Workshops, and Community Engagements. This department is geared more for grassroot efforts, and as such, data was collected through a self-enroll process. The chapter department collected data that was analyzed into **Figures 10-19**. This data was collected from 311 individuals that had attended one of the events that was described above. Both of the data points that were collected were from unique individuals and were cleaned to ensure there were no duplicates and errors.

The program department data that was provided to the student team had 1109 Unique ID participants that was collected from January 2019-2021 has been synthesized with the following points: Demographic information such as race, age, gender, employment status, and education level. In addition, the data identified conviction rates, arrests in the last 6 months, living arrangements, and hospital stays. These have been broken down by either total counts, race, or other descriptors. What is noteworthy is that this data showcases the disparate impact that people of color are not able to access the services. This could be because of where those partners are and barriers to entry. The Figures show the status of housing for respondents. As well as the number of arrests in the last six months by gender of those who are receiving services. Finally, the Figures also illustrate the route of administration (IV, Oral, etc.) for those who have stated they had been arrested in the last six months.

The chapter department data was a self-enrolled process with 311 people responding. What is interesting here is that there is a higher percentage of different race populations that completed the survey. So the total number of surveys that were filled out was actually more responsive from communities of color, although still low as compared to the program department data. These respondents have less barriers of entry, since this department is made up of grassroot services. However, transportation, costs, and other factors are likely still a factor. It is important to note that this data may not be generalizable, as it was conducted from self-enrolled participants and conducted over a three month period.

HARM REDUCTION

Harm reduction incorporates a spectrum of strategies that includes safer use, managed use, abstinence, meeting people who use drugs "where they are at," and addressing conditions of use along with the use itself.[2]

Harm Reduction does the following:

- Acknowledges that people should not need to stop using drugs to receive help.
- Is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use and ineffective drug policies.
- Research shows that harm reduction decreases the negative effects of drug use without increasing drug consumption.
- Harm reduction approaches are facilitative rather than coercive, and aim to reinforce positive change in a person's life, no matter how small or incremental that change.
- Harm reduction seeks to improve drug laws, policies and law enforcement practices, so that they are not detrimental to the health and wellbeing of people who use drugs and their communities.
- Access to high quality, evidence-based prevention, care and treatment programs, including approaches that involve cessation of drug use, are important for some people. Entry into treatment should be on the terms of the individual and must never be forced. Many people who use drugs do not need treatment, and those experiencing problems associated with drug use may be unwilling or unable to enter abstinence-only treatment for a variety of reasons. While abstinence from drug use may be the goal for some people who use drugs, this is an individual choice and should not be imposed, or regarded as the only option.

Young People in Recovery (YPR) acknowledges that it is important to end discrimination against people who use drugs. Experts say it is vital to end discrimination against people who use drugs by reducing the stigma through community interventions. Some of those interventions by YPR is

[2] (Harm Reduction International, 2021)

the Recovery Messaging Workshop[3] that is offered through their chapters. The workshop helps people in recovery to identify and define what recovery looks like for them, personally. It also offers a different approach to identifying substance use and sensationalized nouns such as, addict, and other derogatory terms to be eradicated from experts and community members' vocabulary. Faces and Voices of Recovery (FAVOR) note studies that were conducted that acknowledge this. In addition, they are working to create communities that provide spaces for compassion and continued support of life, that does not discount those who are still using drugs. Accidental drug overdose is currently the leading cause of death in the United States for those under 50. Most of these deaths are preventable.[4]

Drug checking (also known as pill testing or adulterant screening) allows people who use drugs to identify the substance they intend on taking and helps prevent harms associated with unknowingly consuming a substance adulterated with a dangerous contaminant like fentanyl. There are resources like fentanyl testing strips that will help to prevent an overdose by simply testing the substance so you can monitor the amount that you ingest.

On **Figure 17** and **18,** are tables that depict the CDC reporting data that has analyzed the number of provisionally reported overdose of any opioid in 2020 that was reported across all 50 states and the District of Columbia. The report was over the course of 12 months in 2020. The final data was compared to the previous 12 months (2019).[5] The percent change is referring to the relative difference in provisional reports from 12 months of reporting in 2020 calendar year and 12 month reporting in 2019. This analysis found that there was an increase of 29.4 percent change in reports of suspected opioid overdose deaths. It is noted that the data that has been reported may have been late throughout the 2020 reporting time period. In addition, provisional data can be under reported numbers. This is reflected in the notes section as the report was last updated on July 4, 2021. COVID restrictions during the 2020 year may have impacted the number of suspected overdose deaths, although this data has yet to be analyzed. It will be discussed what impact that expansion of naloxone could have impacted this population.

Additionally, research that was conducted by NIDA and NIH[6] found that one in twenty people who sought emergency services for a non-fatal overdose died within a year, many within two days of their visit. It is noted that one in five died within the first month of being discharged.[7] Once more, it was named that two thirds of that population was attributed to opioid overdose deaths. As we have seen opioid use continue to rise in this space, we have seen a rise in deaths associated with substance use. NIDA made a recommendation based on this research that concluded that at this juncture, where emergency services and non-fatal overdose occur, immediate access to treatment or other services would decrease opioid related deaths. This data is limited to the state of Massachusetts, and may not be generalizable. However, there are also limited studies on the process to divert people who use substances to medicated assisted treatment options like buprenorphine. Although, these studies are still limited.

As a final note to this section, experts identified the cost of patients who sought care due to drug use in the emergency department. This was conducted by a study in Florida where Florida's Agency for Healthcare Administration's emergency department conducted an analysis of a dataset from 2016-2018, using data that was collected and met requirements of being seen for

[3] (Young People in Recovery, 2020)
[4] (Harm Reduction International, 2021)
[5] (Center for Disease Control and Prevention, 2021)
[6] (NIDA, n.d.)
[7] (NIDA, n.d.)

substance use related concern and cost-to-charge metric. Then using a linear regression, the study found that total healthcare costs are estimated at $6.4 billion over the 3 year period.[8] The study also found that Medicare paid for the most patient care ($2.16 billion) with Medicaid and commercial insurance each estimated at $1.36 billion. Cocaine use made up 9.25% of the study as poly-use was 6.12%. What experts also found was that **poly-use** increased the costs of an Emergency Department visit compared to a patient with cannabis primary substance use disorder. Opioids made up 23.40% of the study and those increased the cost of patient care, including inhalants use (which made up 16.30.[9] According to The National Center for Injury Prevention and Control, the misuse of prescription drugs alone costs the nation at least $78.5 billion per year. Comparatively, Substance misuse cost an estimated $1176 per capita and Hospital costs have been estimated at $2783 (in 2013 dollars) annually per person with a SUD involving illicit substances. Unfortunately, there is still little data to conclude annual costs of different opioids over other substances. Synthetic opioid use is a growing trend and there is very little data to account for differentiating costs. In addition, as of March 2020, the National Institute on Drug Abuse (NIDA) was citing a 2007 study as the latest available national cost estimates for illicit drug use. Which can be troubling as this data is outdated and not representative of the current population, adjusted U.S. dollar, and current trends.

Naloxone is an inexpensive, FDA-approved generic drug that works to reverse an opioid overdose without any potential for abuse. Narcan® is a brand name for naloxone. Naloxone is a medication known as an “opioid antagonist,” which counters the effects of an opioid overdose. It works by temporarily blocking the opioid receptors in the brain, counter-acting its effects on the central nervous and respiratory systems.[10] Depending on the amount ingested, you may have to administer naloxone multiple times. It is important to contact emergency services immediately because Naloxone only lasts for 30-90 minutes and re-overdose is possible. Narcan has a stronger affinity to the opioid receptors than opioids, like heroin or Percocet, it knocks the opioids off the receptors for a short time (30-90 minutes). This allows the person to breathe again and reverses the overdose. Overdose generally happens over 1-3 hours – not often instantaneous. This led experts to suggesting that having access to narcan is essential to stabilizing recovery initiation. A policy brief written by the National Institute on Drug Abuse noted that in 2017 there were 47,600 people that died from an overdose on opioid drugs including prescription pain relievers, heroin, and fentanyl.[11] Experts note that narcan has been widely available in emergency rooms and first responders. Unfortunately, by the time someone who is experiencing a suspected overdose, it can be too late.

Naloxone distribution programs help to aid in the amount of time it may take for emergency personnel to administer naloxone. Average citizens, who are not medical professionals, can be trained to administer the drug. Thus cutting down the time that it takes for medical services to arrive at the scene of a suspected overdose. Experts noted that a program in Massachusetts reduced opioid overdose death, without increasing use, by an estimated 11% in the nineteen communities that implemented this program.[12] Another study indicated that states that had enacted laws that increased access to narcan showed a decrease in overdose deaths by 14%.[13] Statistical models indicated that states that have enacted laws that increase access to narcan as well as programs that educate lay persons on how to administer narcan avert 21% of opioid

[8] (Ryan & Rosa, 2020)
[9] (Ryan & Rosa, 2020)
[10] (National Harm Reduction Coalition, 2020)
[11] (Scholl et al., 2019)
[12] (Walley et al., 2013)
[13] (National Institute on Drug Abuse, 2017)

overdose deaths.[14]

A state survey indicated that by July 15, 2017, all 50 states had enacted legislation that would expand the access of narcan outside of a medical setting, and to improve access for average citizens.[15] According to the survey, there are only eight states that allow pharmacists to prescribe naloxone. There are twelve states that allow someone to possess naloxone without a prescription. This means that for those states, places like nonprofits, or non-medical service providers are allowed to dispense to individuals and their families. The context that brings to mind are people that are low income and may not have insurance to go to a doctor to gain a prescription. This is also concerning as the majority of people who do not have access to these services are those that really need the accessibility of naloxone without a prescription. According to a press release by the CDC, in rural communities they were three times more likely to be low-dispensing naloxone compared to the urban community.[16] In addition, it was noted that for those with medicare insurance 71% were required to pay a copay for naloxone than the 42% that were covered by commercial insurance. Again, these are individuals who, at minimum, have insurance that are able to mitigate some of the cost of naloxone.

In legal terms, a 'Good Samaritan' is anyone who renders aid in an emergency to an injured or ill person. People using illicit drugs often fear arrest if they call 911 when they witness an overdose. Harm Reductionists are working in communities to educate citizens and policymakers on 'Good Samaritan Laws' which provide immunity for drug violations and for seeking aid when someone has experienced an accidental overdose. A review that was conducted by the GAO, from 17 different studies, found that 48 jurisdictions (47 states and the District of Columbia) have some form of Good Samaritan laws enacted. However, the degree of immunity varies greatly from state to state. On **Figure 22** the image demonstrates what states have enacted legislation and their types. The GAO has noted that there is still limited data in this area and they are unable to determine how laws directly or indirectly affected those seeking immunity and overdose rates.[17] However, the GOA did state that although data is limited, early implications can be made that there is a positive correlation between a decrease in overdose deaths and states that have some form of the Good Samaritan law.[18]

Some states have **Good Samaritan laws** that have immunity for persons who are seeking assistance in "good faith" situations. Good faith is often defined to exclude seeking help during the course of the execution of an arrest or a search warrant.[19] What is important to note is how many states offer expansive immunity that removes fear of arrest at all, like in Vermont. Some states' Good Samaritan Laws provide immunity from arrest, charge or persecution for drug possession/paraphernalia when a person is experiencing an overdose. However, there are other states where this is very limited and they instead turn to the criminal justice system for those that do not meet the immunity criteria. What is noteworthy is that there is a lack of research in the different immunity models. The concerning point is that there is very little data showing what immunity levels states have and whether it is enforced or ignored. The percentage of those who this law is designed to protect may still be diverted to the criminal justice system, limiting the amount people would call 911.

[14] (National Institute on Drug Abuse, 2017)
[15] (Lieberman & Davis, 2021, 1)
[16] (Guy Jr., 2019)
[17] (U.S. Government Accountability Office, 2021)
[18] (U.S. Government Accountability Office, 2021)
[19] (National Conference by State Legislators, 2017)

HIV, also called: human immunodeficiency virus, acquired immunodeficiency syndrome can be spread through intravenous drug use. Harm reductionists help facilitate programs that help people to get tested. Those that are still using drugs and using intravenously have higher risks of contracting the disease. They encourage people to get tested often and to use clean and sanitized syringes and not to share or reuse. The CDC released a report in 2021, data that was captured from 2015-2019 showed that HIV cases had been declining across the country. However, the report noted that for male subjects, the number of cases per 100,000 began to decrease from 2015 to 2019 but for women, cases have been stable.[20] It was noted that white male's accounted for 81% of the HIV infection. In the white female group 40% of the 58% (of those that have the HIV infection in 2019) were from intravenous drug use and multiple risk factors. **Figure's 25**, **26**, and **27** demonstrate the methodology of rates for white, black/african american, and hispanic/latinx populations that are ≥13 years of age.[21] It was noted in an article on HIV.gov that there are more than 25,000 new cases of HIV per year from people who inject drugs.[22] Although this data is from a study that was not specifically focused on these statistics. In addition, **Figure 25, 26, and 27** shows the estimated prevalence of HIV diagnosis in 2019. The question that stems from this data, is how many individuals that go undiagnosed that do not have access to care. In addition, those that do not have access to insurance, may go undiagnosed for an unknown amount of time, and then possibly spread the infection. If there were more points of contact that could help to identify people who are at risk, they could receive treatment and stop the spread of HIV infections. In addition, the lack of data surrounding specific intravenous drug use and rates of exposure could help to identify how the infection continues to spread. Further research could also demonstrate whether intravenous drug use plays a larger role than or not, in the spread of HIV infections.

According to WEBMD, one study found that it could cost from $1,800 - $4,500 monthly for doctor visits and medication. For those that do not respond well to common treatments, they may have to get an injection that costs around $9,000 a month. Those who have private insurance may cover some or all of the costs. However, for those who receive insurance through the marketplace from the **Affordable Care Act (ACA)**, only some of the services will be covered by benefits. There are financial programs that can help those that qualify. In addition, some may qualify for medicare or medicaid. Nonetheless, for those that contract the infection, costs are extremely high to treat, and could be very difficult for low-income or homeless populations.

Sterile syringe access programs help lower the risks of HIV and Hepatitis C by limiting syringe sharing and providing safe disposal options. These comprehensive public health programs exchange sterile syringes and clean injection equipment for contaminated equipment and aid to properly dispose of contaminated equipment.**Syringe Services Programs (SSPs)** reduce the transmission of infectious disease. They are associated with an approximately 50% reduction in HIV and hepatitis C virus (HCV) incidence and serve as a bridge to other health services. Syringe Exchange Programs are community based programs that provide a range of services like access to and disposal of injection equipment, creates linkages to substance use disorder treatment, distribution to naloxone, vaccinations and testing of infections like HIV & Hepatitis C, education about safe use practices. There is nearly thirty years of research that demonstrates

[20] (Centers for Disease Control and Prevention, 2021, p. 5)
[21] (Centers for Disease Control and Prevention, 2021, 49-55)
[22] (HIV.Org, 2020)

that SSPs are safe, effective, and cost-savings.[23] Studies have shown that they do not increase drug use or crime.[24]

In **Figure 28,** the CDC surveyed states to determine which were in need of access to Syringe Service Programs due to being at higher risk from intravenous drug use. The CDC had conducted consultations in order to determine the need for Syringe Service Programs. As a result of these findings among other risk factors and under the Consolidated Appropriation Act of 2016, federal law permits use of funds from the Department of Health and Human Services (DHHS) to support syringe service programs with the exception that funds may not be used to purchase needles or syringes.[25] Although federal dollars can not pay for syringes, they can pay for testing services, personnel, naloxone, educational materials, condoms, communication devices, and non research activities. There is a disadvantage to not getting funding to cover the cost of syringes which would alleviate these services from having to depend on other grants or fundraising in order to support syringe access. This leaves the bill up to the service providers. Which, as shown in **Figure 28** is the majority of the country. The questions that this raises is why is the cost of syringes not able to be paid through funding from the federal government, if they have met the requirement by the CDC - that they need these services? Once more, it puts these community organizations at risk for not being able to provide the service because of the costs. This basically sets the standard that you can create the service, but we won't support the product that the community needs in order to stop the spread of infection.

As a final note on SSP's, as the research was conducted, there was little data on access to services that were not affiliated with the CDC making those determinations. In addition, it was not noted the amount of time it took from the point that the CDC made their recommendations, based on their findings. Then for agencies to apply to start services, and the implementation process. Although all programs take time to start, this also prevents people from receiving services as the bureaucracy of being approved. As we have already discussed in this analysis, drug overdose, and the spread of infection are prevalent and having this as a standard service that is provided to the community may help alleviate some of these concerns.

Supervised consumption services (SCS), Safe Injection Sites (SISs) also called overdose prevention centers and **supervised injection facilities (SIFs)**, are legally sanctioned facilities designed to reduce public safety issues and increase public health often associated with public drug consumption by allowing on-site, supervised use of drugs. These sites have been historically illegal in the United States. However, there have been numerous countries around the world who have implemented these public health institutions. Studies in recent years (2018) show evidence suggesting that SIS's are correlated to lower mortality rates, 88 fewer overdose deaths per 100 000 person-years, 67% fewer ambulance calls for treating overdoses, and a decrease in HIV infections. Unfortunately these studies have only been conducted out of the United States, so the effect of these programs is limited.[26] In the United States it is illegal for these sites to exist and operate. This is because of the **Controlled Substances Act (CSA)**

[23] (Center for Disease Control and Prevention, 2019)
[24] (HIV.Org, 2020)
[25] (Center for Disease Control and Prevention, 2020)
[26] (Sutherland et al., 2020)

federal law interpretation prohibits any person processing illicit drugs and any place operating that allows use of illicit drugs on its property. And as a result these punitive laws have continued to fail to curtail the opioid epidemic.

Looking at a study that was conducted in Vancouver, BC experts noted that in one month near a SIS, there was a 67% reduction in emergency service calls for naloxone in the area.[27] The calls went from 27 a month to 9 calls. Although, again it is difficult to say if this is generalizable to the US and depending on the surrounding population of the SIS location, but these findings show a strong correlation of decreased lengths of hospital visits, and by mathematically modelling, 6 - 57 HIV infections are prevented by this program and Syringe Exchange Programs. A SIF in Australia noted that there were no deaths from 5,925 overdoses from 965,000 supervised injections from 2001-2015.[28] Although these cases have shown progress in public health and safety the United States has stood firm in its decision to not allow Safe Consumption Sites within the country.

There is speculation that there are SIS's in the United States, called Clandestine SIF's. However, this research will not be able to identify any data or studies that have been conducted at those locations. It was also noted that as of April 2018, 78 official SIFs operated in Europe (Denmark, France, Germany, Luxembourg, Norway, Spain, and the Netherlands), as well as in Australia and Canada.[29] Ireland and Portugal recently authorized SIFs in their respective countries. So the question to raise is why the United States is so against allowing Safe Use facilities to operate? What can be done about the Controlled Substances Act and how to navigate policies that don't protect public health.

The policy implications for Safe Consumption Sites are hardly known. There is limited data that can be generalized for the United States specifically. There are some studies on Clandestine SIFs, unfortunately those are unreliable and due to its illegal nature, it would be unethical to quote or cite data or any findings in those reports. In order for there to be more research to be conducted this would mean a complete turn around from previous federal mandates. However, this would not be out of the ordinary. When states like Colorado made recreational marijuana legal, the Department of Justice (DOJ) has yet to storm into the city and arrest dispensaries.[30] As more and more states change their statutes to allow for recreational use of substances that the Department of Justice had deemed illegal or illicit, the argument for more support for Safe Consumption Sites may change. In 2017, a task force in Massachusetts characterized a SIF as treatment for the at-risk person. Changing the perceptions of local and state officials may be the mark of pushing federal policymakers to change laws.

Recommendations

As it was stated, Hospital costs have been estimated at $2783 (in 2013 dollars) annually per person with a SUD involving illicit substances.[31] What is noteworthy, is that the amount of possible interventions at emergency departments could be a potential for divergent care as noted in the study by NIDA. In addition, NIDA is citing data that is from 2007, which can be troubling as the data is outdated and not representative of the current culture.

[27] (Sutherland et al., 2020)
[28] (Gostin, et al., 2019)
[29] (Gostin, et al., 2019)
[30] (Gostin, et al., 2019)
[31] (Ryan & Rosa, 2020)

- More research needs to be conducted in this area to focus on more immediate intervention, especially in emergency departments to support diversion to a path to treatment.
- Naloxone expansion has been facilitated across the country. However, for those who do not have insurance, access to care, or low-income can not access. More research is being done to create “over the counter” types of naloxone distribution. YPR should help to support this effort. Making recommendations to policymakers to allow pharmacists to dispense the naloxone (especially with those who are prescribed strong opioids by a physician) without the requirement of a prescription.
- More research needs to be conducted that collects levels of Good Samaritan Law levels across the 50 states (those that have enacted legislation) and look at whether the effect of diverting possession/paraphernalia charges, overdose rates, number of police responses to emergency scenes.
- There is a need for more targeted research to address inequalities of HIV and Hepatitis C prevention, testing, and treatment. In addition, conducting studies that could help to determine what role intravenous drug use plays in the spread of HIV and other infections.
- Conduct research to determine the need for syringe costs and funding. Determine if funding would help to alleviate the cost burden on service providers. Determine if these costs have prevented service providers from being able to dispense syringes. Determine if additional funding would expand services and provide adequate access for syringes and other material at Syringe Service Program locations.
- Research to be conducted that could determine if Syringe Service Programs would alleviate the spread of infections like HIV and Hepatitis C to follow the CDC plan to end HIV by 2030.[32]
- A change in policy and interpretation is needed in order to conduct research on Safe Consumption Sites in the United States. Experts and studies can be used to demonstrate the need to conduct research. However it would be wise to try and leverage data from other countries to allow the US to promote case studies that can be facilitated on US soil.

[32] (Centers for Disease Control and Prevention, 2021)

HOUSING

Maslow's ‘Hierarchy of Needs’ suggests food and shelter are the two most essential needs. A person will not be able to consistently put mental or physical energy into other more abstract needs, such as the needs for improving health, interpersonal relationships, self-fulfillment, etc., unless they start with having food when they're hungry and a stable, secure roof over their head. Without these supplies, all other endeavors in life become significantly harder to navigate. Food insecurity for underprivileged groups is certainly a worthy cause to devote time to solving. However, for the purposes of this section, the topic of stable housing and how it relates to addiction recovery will be the focus here.

Housing for people recovering from SUDs is vital to their ability to maintain their recovery status. Homelessness and unstable housing often present yet another barrier to the health of a person fighting to achieve and maintain sobriety. It leaves a person susceptible to higher chances of becoming a victim to violence, exposure to diseases, or injury/death from extreme weather events. This is undoubtedly a significant amount of mental energy and stress that could be devoted to recovery and wellness, but instead leaves a person already struggling in “survival mode”. However, one particular solution provides an answer to this problem: The Housing First approach. Housing First seeks to provide safe, stable housing for people struggling with homelessness and other behavioral health issues. According to the National Alliance to End Homelessness, “Housing First does not require people experiencing homelessness to address the all of their problems including behavioral health problems, or to graduate through a series of services programs before they can access housing….The Housing First approach views housing as the foundation for life improvement and enables access to permanent housing without prerequisites or conditions beyond those of a typical renter.” [33]

[33] NAEH, 2016

Some may not support Housing First for those recovering from a SUD because they may view it as condoning or enabling substance use by providing them with free or discounted housing at taxpayers' expense. This however, is not the case. The implementation of Housing First in cities actually has strong correlations with reductions in the severity of an addiction.[34] This means that substance users who are matched with housing due to Housing First participation use less amounts of intoxicating substances with less frequency than their homeless counterparts. For homeless individuals with co-occurring illnesses such as mental illness and substance use, researchers found that the, "utilization of emergency room care, inpatient medical and psychiatric care, detox services, incarceration, and emergency shelter were significantly reduced by participation in the program."[35] Data repeatedly supports the fact that with Housing First, individuals and/or their families remained housed at significantly higher rates, and used emergency services or hospitals at statistically significant lower rates.[36] It should be noted, however, the Kertesz article questions the extent of the positive influence Housing First programs have on rates of abstinence amongst Housing First participants with a SUD. They state that they have not found enough concrete evidence to support a correlation to Housing First and abstinence rates, although they do concede that more research needs to be done because the topic is under researched.

The highlights of a case study conducted by Jennifer Pearlman and John Parvensky of the Colorado Coalition for the Homeless who examined the cost benefit of program outcomes for the Denver Housing First Collaborative (DHFC) A few of their most notable findings include:

- Overall, the sample group saw reductions in the cost incurred from emergency room visits. "The total emergency related costs for the sample group declined by 72.95 percent, or nearly $600,000 in the 24 months of participation in the DHFC program compared with the 24 months prior to entry in the program. The total emergency cost savings averaged $31,545 per participant over two years."

- "Detox visits were dramatically reduced by 82 percent, with an average cost savings of $8,732 per person, or 84 percent."

- "Incarceration days and costs were reduced by 76 percent, and emergency shelter costs were reduced by an average of $13,600 per person."

This means less taxpayer money spent on this issue, money which can be reallocated for community needs. Another study which investigated the compound problem of homelessness, mental illness, and substance use found that the Housing First model led to "significantly faster decreases in homeless status and increases in stably-housed status relative to participants in the control condition," the "control condition" being that of people participating in housing programs that imposed sobriety requirements and program participation on its recipients. This study not only provided evidence to dispel beliefs from professionals who may think the "chronically homeless" are not "housing ready", but also showed that non-housing first models don't guarantee sobriety anymore than housing first models do, as no significant differences were shown between the experimental (housing first) and control groups (Continuum of Care) in terms of substance use.[37]

[34] Kertesz et al., 2009
[35] Perlman & Parvensky, 2006
[36] Kertesz et al, 2009
[37] Tsemberis, Gulcur, & Nakae, 2004

Other similar models such as Rapid-Rehousing have shown similar results, although these models are usually geared towards helping people who are in recovery after major national disasters where you see displacements in large numbers. The concept, however, is much the same as Housing First and would likely have the same amount of success on any person recovering from substance use. In fact, a study by the Urban Institute argues that traditional transitional housing programs are actually more costly than what they seem to be worth per the weak outcomes they produce. "For such weak results, transitional housing is costly: about $40 to $149 a night, depending on the city, which roughly translates to $1,200 to $4,470, a month[38]. Given the high rate of families who exit to other subsidized housing, transitional housing has become an inefficient and costly waiting room—holding families in temporary housing while they complete a series of service requirements that do not increase success rates."[39]

Oxford Houses (OHs) and Sober Living Houses (SLHs) involve much more autonomy in their models. They are a type of recovery housing that are self-run by the residents. Most do not offer on-site treatment because these are often not able to be provided by the operator. Unlike OHs, SLHs do not have counselors, or other recovery paraprofessionals. Essentially, these are environments where house residents democratically decide house rules, pay their portion of the rent and abide by the rules everyone agreed upon. These models have been able to boast a tremendous amount of success with helping people in recovery attain stable housing. However, they do not offer comprehensive recovery services and therefore limit a person's recovery capital. This is not ideal as researchers have seen trends to suggest that recovery houses that "...were affiliated with a treatment program, and had referral arrangements with probation/parole would have better outcomes, as these factors would reduce resource scarcity."[40] Also, if a resident has a setback in sobriety, they risk losing their housing placement if their fellow residents vote them out. The possibility of returning to homelessness due to a relapse is obviously counterproductive, as it puts a person in recovery back to square one.

Recommendations

The extent of the cost-benefit to a city or town aiming to implement Housing First programs has not been determined. But a proven net benefit to formerly homeless individuals is great. YPR stakeholder should invest in "Housing First" efforts to help provide stable housing for clients while they are recovering from a SUD. Other recommendations include:

- Push partners to push via lobbying or funding the support of establishing/expanding Housing First initiatives in target areas
- Push for "warm-hand off care", promoting collaborations with treatment centers, recovery support orgs to streamline care.
- Oxford Houses and Sober Living Houses (SLH), while not as ideal of a model according to YPR philosophy, should not be totally discounted. These approaches also have proven success, although the sobriety stipulations might make them more appropriate as a more long-term option for a person in recovery. Research examining possible partnerships with OH's and SLH's to guarantee housing for clients who do well in a Housing First environment and maintain sobriety long enough to qualify for placement into one of these houses.

[38] Spellman et al. 2010
[39] Cunningham, Gillespie, & Anderson, 2015
[40] (Mericle, 2019)

CRIMINAL JUSTICE & JUDICIAL

Many individuals with substance use disorders go on to commit criminal infractions. This is an issue that further expands the burden on the criminal justice system. There were 1,558,862 Americans arrested with drug abuse violations in 2019.[41] The crime that led them to serve time is most likely related to their substance use disorder. But substance use does not end in incarceration. Most common crimes committed from people with substance use disorder are possession, intent to distribute, burglary and assault among other offenses. The individuals could have had illegal substances on them. They could seek to commit theft to earn money for their habit. As well as, have episodes of violence while intoxicated. Whatever the case may be, these crimes directly resulted from their addiction. A possible defense is their lack of sound judgement, but many offenders acted with intent; therefore, it is likely for the defense to not be upheld.

Inmates currently using, are likely to experience withdrawal symptoms and other adverse effects from immediate substance removal. The criminal justice system is aware of the problem that drugs, and alcohol are readily available in their facilities. Constant vigilance in prevention is made to limit drug trafficking. While in jail, the first step in recovery is detoxing the inmate. The inmates are not guaranteed treatment, but the solutions range from detox cell holding with medical professionals to direct movement into the general population. This leaves the inmate to fight their withdrawal without treatment. Intervention is necessary for the wellbeing of the inmate.

There are special programs in prisons to start inmates on the path to recovery. These are called **Drug Courts**. Drug Courts are special magistrates which recognize the importance of continuing recovery efforts while serving time. There are more than 3,500 drug courts across all 50 states and approximately 200,000 Americans, annually, are participants of the drug court program[42]. Please see figure 23 of the map of drug courts in the United States. California leads with 120 drug courts. Not all state and federal drug courts operate in the same ways, but the backbone is the same in structure and scope to reach their target offenders. The program uses supervision, random drug testing, treatment, sanctions and incentives to keep inmates on the path of recovery. They work in collaboration with judges, prosecutors, defense counsel, treatment specialists, probation and law enforcement officers, education experts, community leaders, and other experts. The incentives are usually time taken off from their sentence and

[41] FBI, 2019
[42] Strong, 2021

likewise, the sanction is time added. The program is intended to reduce drug relapse, accidental overdose and recidivism. The program is carefully designed through risk and needs assessment of the local population. The purpose is to give these offenders the necessary help they need to break the cycle of addiction and the revolving door of **recidivism**.

The first drug court opened in 1989. Under the Obama Administration, the Department of Justice studied the effectiveness of these courts for over 20 years. The concluded, “in times of serious budget cuts, the drug court model offers State and local governments support for increasing and enhancing access to substance use disorder treatment.” During the DOJ's review of independent meta-analyses, they determined drug courts significantly reduce crime by an average of 8 to 26%. Well-administered drug courts were found to reduce crime rates by as much as 35%in a fiscal year.[43] The program is not easy for the participants and requires adherence to the core guidelines. This program model has been proven to be successful.

The DOJ found the program’s structure of integration of alcohol and other drug treatment services within the justice system to curb recidivism. Compliance of the program guidance is crucial to aid in their recovery and prevent sanctions. Positive support from law enforcement, prosecution and defense counsel are shown to promote public safety while protecting participants’ due process rights. A police presence is shown to have a higher drug court graduation rate compared to programs without – 57% vs. 46%.[44] The participants’ ability to learn and graduate from the program and stay on their path of recovery is dependent on a coordinated effort of all parties. Feedback and communication from their counsel or public defenders and other constant judicial interaction is important to the supportive environment. “The magnitude of a court's impact may depend upon how well the practitioners address and balance these core components and adapt to the needs of their clients and court staff”.[45] Criminal justice costs were reduced by 36% since drug courts were enacted, this information is current as of 2008.

Special attention to minors is given in the juvenile justice system. Family drug courts offer parents and caregivers, who have a child with an alcohol and other drug dependency problems, along with the offenders, are taught how to build skills to increase their ability to lead drug and crime-free lives. This aims to strengthen the family’s capacity to instill structure and guidance in their young lives. Families are responsible for the actions and behaviors of their children. The mission of family drug court is to promote accountability for all involved.

Not all people convicted of a drug related crime are selected for drug court. Early identification of eligible participants and prompt placement gives the offender a head start in their likelihood to complete the program. There are many variables that factor in the selection for the program: availability of program slots, severity of addiction, drugs used, and criminal history. Caucasians and African Americans are the most predominant racial groups in drug courts. Caucasians were reported to represent nearly two-thirds, 62% of drug court participants. There is a considerable difference across jurisdictions. In some drug courts, nearly all of the participants were reported to be Caucasians. [46]

Racial and ethnic minorities were reported to be both dominant and underrepresented in prison demographic samples. Racial populations fluctuate in different geographical areas. But the

[43] Obama Administration, 2008
[44] Obama Administration, 2008
[45] Obama Administration, 2008
[46] Huddleson, 2011

issue of disparity by race in criminal court is prevalent. African Americans are nearly five times more likely to be incarcerated in prison than Caucasians.[47] Please see Figure 29. There is a disproportionate impact black and brown people in the screening, evaluation, diagnosis and treatment of people with mental health problems, including substance use disorders. White, non-Hispanic people are more likely to have pre-trial diversions.[48] Therefore, in statistical significance, being White gives the inmate more of a chance to be selected as a drug court participant.

In a financial point of view, there are many cost-savings associated with the success of drug courts. The Urban Institute found that drug courts provided $2.21 in benefits to the criminal justice system for every $1 invested. When expanding the program to all at-risk populations, the average savings increased resulting in a benefit of $3.36 for every $1 spent.[49] The reduction of overdoses and overall substance use reduces emergency medical costs. Understandingly, treatment costs are high at first, but with less recidivism, drug courts saved an average of $5,680 to $6,208 per individual overall.[50] The Bureau of Justice Assistance (BJA) found statistically significant data indicating lower re-arrests. When conducting a cost-benefit analysis, the average "net benefit ranged from positive $47,852 to negative $7,108 per participant".[51] Inclusively, there is a decreased governmental expenses; thus, taxpayer dollars.

Drug Courts also help to provide guidance to drug offenders to collaborate with intervention agencies and other support resources. This program increases cost-effectiveness to the taxpayer by lowering rates of recidivism.[52] These drug-intervention programs work by introducing a moral compass within the individual. The mission is to improve their quality of life, physical and mental health. The overall success of the participants who receive these resources is grounded in long term recovery. The goal is recovery not punishment. The wish is for them to recover from their addiction and prevent future criminal charges. Successful graduates of drug court are matched with reduced sentences and fines.

America's northern neighbor, Canada, has established a progressive and effective mainstream court model in Vancouver. The Drug Treatment Court of Vancouver (DTCV) provides support and treatment for individuals with substance use disorder, voluntary setting not committed, in a 14–16-month outpatient treatment center. A team of social workers, healthcare professionals and employment assistance personnel collaborate on the individual's complex needs to curate tailored solutions with innovative strategies. "An evaluation of this program found it reduced drug-related recidivism by 50% over a two-year period." The case managers and experts found the common requests the recipients needed were basic necessities like transportation, food and shelter to further their success.

Washington State has successful drug courts and monitors the program's performance. The data captured in their study relied on demographics, criminal histories, history of treatment and other relevant characteristics. They then compared treatment, employment, re-arrest and incarceration rates to a control group (corrections facility without a recovery plan) for comparison. They found released inmates that graduated from their program more likely to be employed and they had lower arrest rates for non-drug related crimes. "Recovery support

[47] Kaba, et al, 2015
[48] Schlesinger, 2013
[49] Roman et al, 2003
[50] GAO,12-53
[51] GAO,12-53
[52] Corrections, 2021

services appear to increase employment and reduce the likelihood that drug court participants will commit new crimes or become incarcerated".[53] Housing stability needs were resonated to support program utilization.

More studies have been conducted to assess the validity of the drug court model. The Government Accountability Office (GAO) conducted a study in 2010. The DOJ requires corrections facilities to submit data on their metrics of performance. The report evaluates the validity of the data collected and effectiveness of drug courts. "The GAO assessed performance data the DOJ collected in fiscal year 2010 and reviewed evaluations of 32 drug- court programs and 11 cost-benefit studies issued from February 2004 through March 2011".[54] The defining variable was completion rates.

The traditional police officer has an important role in the model. They are tasked to submit referrals to the court, monitoring the paroled participants and looking for patterns of behavior in the community. Street-level public servants are essential in showing the local government and interest organizations the effectiveness of public safety in regard to reducing drug-related offenses.

Reducing recidivism is a large component of the drug court model. Recidivism is measured as an arrest for a serious offense after release from a corrections facility. "A study funded by the Department of Justice examined re-arrest rates for drug court graduates and found that nationally, 84 percent of drug court graduates have not been re-arrested and charged with a serious crime in the first year after graduation, and 72.5 percent have no arrests at the two-year mark"[55] It is reasonable to suggest previously incarcerated individuals are likely to repeat offenses. One out of six drug court graduates are expected to be re-arrested and charged with a serious crime.[56] More support needs to be performed to increase the 70% success rate; less than 30% is still a large part of this population.

Federal attention is being given to the drug court programs. The Office of Juvenile Justice and Delinquency Prevention funded 24 million to Family drug courts and juvenile drug treatment programs.[57] Remaining in the status quo, these available funds do not reach the amount of people incarcerated with a substance use disorder. "Substance abuse costs our Nation over $600 billion annually." Treatment is less expensive than incarceration. The average cost for 1 full year of methadone treatment is approximately $4,700 per patient. One full year of imprisonment costs approximately $24,000 per person.[58] A savings of $19,300 per person.

Drug courts aren't the only solution. The Substance Abuse and Crime Prevention Act (SACPA) established **State Mandate Drug Treatment Programs (SMDTPs)**. These programs have a promising use for the community-ready model. The SMDTP model consists of direct support with substance use treatment, education of healthy living and help to find permanent housing. This program is only eligible to people convicted of low-level crimes and nonviolent drug possession charges.

The criteria for measuring the program success are reduced recidivism, lower crime rates in the

[53] Washington State Courts
[54] GAO,12-53
[55] Huddleson, 2011
[56] Roman et al, 2003
[57] Drug Courts, 2020
[58] NIDA, 2020

community, graduation of the treatment programs, less overdoses and less drug use in general.

In comparing both programs, the drug court model had larger success in producing higher rates of treatment completion; they also had lower recidivism rates than other criminal justice models. Drug courts are very costly to implement at the local level. Judicial involvement and rigorous team efforts and treatment resources in drug courts can be expensive for local courts to implement. The tradeoff is the expensive initial costs, but the long-term savings will hopefully outweigh the expenses. The SMDTPs model, a non-incarceration option, is a potentially less costly approach since it requires less court time, per participant, thus it can be implemented easier for larger populations. The SMDTPs can reach a large number of eligible offenders, "offering treatment for their substance abuse without incarceration."[59]

Both utilize treatment and probation resources. The programs need to work otherwise cost savings will cease and there will be lower graduation rates and higher recidivism rates. The SMDTPs offer flexibility to the localities since each county is given 'freedom to create their own program' based on the available funds, resources and population trends.[60] Each program has aspects of controversial approaches to support people on the path to recovery. Some more conservative policy makers may have negative feelings towards helping people with substance use disorders. In advocacy efforts, the message should be focused on public health matters not a criminal issue, thereby eliminating a moral/ ethical dilemma.

Progress is short-lived since this program is more available at federal and state levels. While the studies have strong validity, they are not timely, which is a limitation to the program's concluded success and performance. Support is echoed in fostering collaborations and partnerships with drug courts, public agencies, and community-based organizations to create local support and enhance drug court program effectiveness and advocacy.

The drug courts and SMDTPs within the community-ready model bestow purpose, value, importance and support on the offender while they continue on their path to recovery. Locking up people does not eliminate the drug and addiction problem. Federal framework depicted in this analysis ensures transformation for urban, rural and suburban settings. There are limitations to the number of inmates accepted into the drug court program. Transparency in the data is needed so team developers cannot "cherry pick" certain candidates so as to influence the success of the program – the best and worst candidates or racial/ethnic factors. There is no metric to determine the severity of the individuals' addiction and substance use disorder. There isn't enough information to determine if the support methods are tailored to the participant. We are not confidently able to forecast how much crime could be prevented within a calendar year. Historical trends and years of difficulty like the Great Recession, years of war, 2020's impact of COVID-19 and other hardships create an influx that researchers may not be able to predict drug-related crime rates.

Recommendations

- Increased advocacy at the state and local government level is most needed to support this program locally. The message to policymakers is to support expansion of substance use treatment because it produces benefits of crime reduction and improved public safety. This is a public health problem not a criminal issue.
- Since current studies are not readily available to provide data-driven proof of successful

[59] Carey, et al, 2008
[60] Carey, et al, 2008

performance of the programs more research is needed to make accurate and transparent conclusions. A survey using population samples should be used in an analysis to capture a true illustration of the residents. The evaluation must use demographics, locality budgets, resources and other variables to effectively measure the use and achievement of drug court program goals.

- More current research is needed to determine if minority citizens are being denied the opportunity for Drug Court for reasons unrelated to their eligibility – racial and ethnic injustice.
- Drug courts are effective in their efforts to support people with substance use disorders. Continuing interdisciplinary education is needed to promote effective drug court planning and its operation.
- Further adaptation of State Mandated Drug Treatment Programs has promising results to divert non-violent treatment and rigorous standards of accountability.

RECOVERY SUPPORT

Many people view recovery as a finite or closed process. A person develops an addiction at one point, and it may last for a long time, but they are "cured" when they never want to touch that substance they're addicted to ever again. This line of thinking is erroneous. Addiction is a chronic disease and the recovery process is never finished. No person with a substance use disorder is ever truly cured. Instead of acute care models, people in recovery need a model of care which recognizes the perpetual nature of the recovery process. This is important for supporting a person so they can maintain their recovery status during their lifetime.

Recovery support is vital to growing or maintaining a person's **recovery capital** when they exit a treatment program. Recovery capital comes in many forms, and proper support is imperative for keeping a person in recovery. People in recovery must be engaged within their community, invested in their well being, and committed to their healing. Michael Kidorf et al. conducted a small study whose results suggested recovering users could possibly see significant positive impacts from doing a survey of drug-free social contacts in their networks. "Spending more time with drug-free network members would provide opportunities to enhance recovery-oriented support, which would likely have a positive impact on treatment outcomes and functioning.[61] It might also produce new advocates for treatment and recovery, and help reduce stigmas associated with substance use disorder and its treatment." [62]There is a great need for recovery support programs that also get family members and friends involved in the recovery process too, as these people so often comprise the circle of support a person will need to keep sobriety. They too, are a major feature of a recovering substance user's recovery capital. Research cited in a study conducted by Vanessa H. Woodward demonstrated that family involvement in a persons' recovery can have major positive or negative impacts depending on the strength of a person's social bonds and attachment to their family.[63] A person with a healthy, strong attachment to a supportive family will have higher chances of maintaining sobriety compared to a person with unhealthy, low attachment to a discordant family who will have higher chances of continued use or relapse. [64]Also noted, the limitations of family-focused models in their study's discussion section, stating that the presence of a partner or other close relationship where that person uses illicit drugs and the required specialized training that is rarely available to

[61] Stout et al., 2012, Warren et al., 2007
[62] Kidorf et al., 2016
[63] Woodward, et al., 2014
[64] Kidorf et al, 2016

community-based treatment programs are hindrances to recovery capital.

Education to the public on the recovery process is also a major factor in successful recovery support. A community benefits when its members are educated on the needs of those in recovery about what they might encounter as they go through the process, which can translate into making prevention efforts more effective. Educational programs on SUD recovery can serve to correct misconceptions about people who are recovering, and lessen or eradicate social stigmas that come with this status. Some of the most harmful beliefs about people recovering from addictions are that they have become “addicts,” because they have moral failings, not because of being exposed to substances which have literally altered their neurochemistry and physiology. Addiction should be viewed as a disease vs. a moral failing or maladaptive choice. Even the language around the topic of addiction is important, and emphasizing “person-first” language can automatically fight thoughts or beliefs which speak from a model of deficit to one that recognizes both vulnerabilities and strengths, but does not disparage shortcomings.

In behaviorism, various theories have been proposed in order to explain deviant behavior. How a “deviant person” is labeled by themselves or society, and *how much* that label affects their future behavior is a theory that has been purported by one school of thought or another. One such approach attempts to assess how stigmas affect the individual. In John Braithwaite’s (1989) theory, **“reintegrative shaming”** is used to shame the actions of an offender, but not the offenders themselves. It is hoped that this process will allow offenders (or substance abusers) to reintegrate into the community. **Disintegrative**, or **stigmatizing shaming**, expresses disapproval of an individual with a lack of forgiveness or reintegration into society." [65]

Reintegrative shaming i.e., "That child did a bad thing" vs "That child is bad", essentially separates the action from the person's identity, therefore giving them more agency and choice when it comes to modifying their behavior. Within the context of SUDs, this approach in a peer-support system would be utilized to discourage relapses. While certainly preferable to outright stigmatizing shaming, because it does acknowledge the possibility for redemption rather than surrendering to the thought that a flaw is inherent to a person's nature, reintegrative shaming is still unhelpful in that it presents addiction as a choice and not a disease. "There was only a small distinction in references of reintegrative shame between both groups, 26.3% of those in recovery versus 21.1% of those still using alluded to elements of reintegrative shame.” [66] The study presented evidence that using reintegrative shaming for substance use may only account for marginal differences in those currently abstaining from substance use versus those who are not. “Disintegrative shame, however, was much more prevalent in the journal entries of members who were still using (42.1%) than in the entries of those in recovery (10.5%).”[67] Granted, partaking in drugs and other substances for the first time may have been a choice, however that “choice” erodes the more a person's body develops a chemical dependency on a substance. Thus, making usage less about choosing and more about survival. When this dependency occurs, shaming of any kind is prone to make the person default to hiding their behavior rather than seek treatment or counseling for it. Thus, shaming in any respect is counterproductive to recovery.

People in recovery, unfortunately, often experience the latter type of shaming by society at large due to high amounts of negative attitudes and incorrect public perceptions about them. Shaming as a punishment and social deterrent is unmistakably effective. If society refuses to see a

[65] Woodward et al., 2014
[66] Woodward et al., 2014
[67] Woodward et al., 2014

person with an SUD beyond their use of the substance they are chemically dependent upon, the recovering user's ability to achieve and maintain abstinence will be much more difficult. For successful expansion of recovery capital, "…members of the community must forgive an offender and allow him or her to reintegrate into society."[68] Without this type of support, communities will most likely contribute to a significant reduction of social ties in this population.

An increasing number of public health departments and city or state governments are implementing a relatively new model of care that takes all of these issues into account. A **Recovery-Oriented Systems of Care** model is person-centered, offers individualized services over a person's lifespan, is "culturally responsive" to the needs of individuals in recovery and their families, is evidence-based and utilizes a "recovery plan" instead of a "treatment plan". It is comprehensive and meant to be inclusive of the different areas associated with recovery, from recovery housing to laws to education. This model considers the recovery process on the principle that, "Recovery exists on a continuum of improved health and wellness".[69]

Saitz listed numerous components of chronic disease models that have been proven effective in the treatment of SUDs. The following are a few of those results cited in their study:

- "Case management was associated with greater receipt of alcohol, medical, psychiatric, employment, and family services, and with less alcohol intoxication (and lower severity), and fewer days of psychiatric and medical problems."
- In comparison to programs without such features, it was found that providing, "primary medical care by off-site referral or on-site at drug treatment programs…." reduced both emergency rooms and hospital visits, and was also correlated with "reduced addiction severity".
- "In a randomized trial, patients receiving on-site medical, psychiatric, employment, and family services had less opiate use, and improved medical, employment, legal and psychiatric outcomes."
- The option of on-site primary care in conjunction with drug and alcohol addiction treatment programs showed higher efficacy rates in clinical trials for medication-assisted treatment such as naltrexone, acamprosate, and buprenorphine.

In summary, individualized attention from case managers and readily accessible primary care leads to less time spent intoxicated, less time spent in the emergency room or hospitals, lessened severity for addiction or psychiatric episodes, and improved outcomes for holistic well-being and medication-assisted treatments. This translates to reductions in costs that would be significant on a long-term basis.

Further evidence to support conclusions from Saitz, a four-year trial on Chicago residents was conducted by researchers McCollister, results published in 2013. Their findings were that there were statistically significant differences in the rates of abstinence, substance-use related problems and cost-effectiveness. While the treatment group, recovery management care + outcome monitoring (RMC) cost more upfront compared to the control group, "outcome monitoring only (OM)", ($2,184 more than OM-only ($p<0.01$), participants who received recovery management care averaged more than 1000 days abstinent and had under 100 substance-use related problems. The OM group on the other hand averaged just over 900 days abstinent and had over 125 reported substance-use related problems. When calculating the cost-effectiveness ratio after additional related costs to society were factored in, the treatment group (RMC) cost less for more efficient treatment.

[68] Semple et al. 2005
[69] Kaplan, 2008

Recommendations

Promoting a recovery-oriented systems of care model aligns with YPR's vision to help persons in recovery, their families, and their surrounding community make providing the proper support a lifetime process, not a temporary one. YPR's stakeholders should support these programs in the states they serve.

- If no recovery-oriented system of care exists where stakeholder constituents are located, network with different partners in order to get a plan for one developed and implemented.[70]
- Many of the community-based organizations which partner with their respective states to implement its recovery-oriented system often face barriers in securing funding. This is largely due to "… most faith-based and peer recovery support services are grassroots organizations that lack the infrastructure needed to comply with Federal, State, or local reporting requirements. They often do not have appropriate accounting systems in place to track and justify grant or reimbursement payments."[71] In order to compensate for these organizations' lack of experience with these procedures, YPR stakeholders should fund the creation, supply and distribution of training materials on how to help community partners set up the infrastructure needed to get these grants approved for their organizations.
- Consider ways to give those managing recovery more autonomy in their recovery plans. Encourage partners to apply for grants via Access to Recovery, a grant program funded by SAMHSA/CSAT which offers vouchers for patients to choose their own treatment providers and counseling programs for recovery plans from an approved list of providers.
- There is very limited research as to the efficacy of these systems of care, and not many of the states who use these systems publish public cost-benefit analyses conducted on their programs. Sponsoring more research to be done on the implementation of these systems would also help provide evidence that these systems work.

[70] Kaplan, 2008

[71] Kaplan, 2008

EDUCATION

Battling a chemical dependency while trying to learn and earn a diploma is difficult for most people who go through this experience. Even in instances where young people are able to put their academic career on hold while in treatment, coping with triggers in healthy ways and trying to stay sober amid school environments which normalize binge drinking and experimentation with drugs is a formidable task. A survey conducted in 2015 estimated that almost 22% of "...high school students were offered, sold, or given an illicit drug on school property…" and another "...found that virtually all adolescents returning from treatment to their old school reported being offered drugs on their first day back in school."[72] For college campuses, on average over 80% of college students drink and over one third of the student body engages in drug activity. Trends in data collected since 2007 display increases in both frequency and amounts of drinking alcoholic substances by college students to a point where binge drinking and experimentation with drugs is considered an expected part of the college experience.[73] In both environments, recovering students must grapple with being exposed to peers who actively use drugs and alcohol, the easy availability of these substances, as well as academic and social challenges common during these most formative years. It is almost as if they are being set up for failure.

Students with SUDs are entitled to accommodations under the Americans with Disabilities Act, but recognition of their needs at a systemic level is still lacking.. Automatic supports built in to accommodate people with medical needs such as diabetes, digestive disorders, food sensitivities or allergies, etc., are more commonly known, but not many built-in supports for students recovering from a SUD exist. Diversity Equity and Inclusion (DEI) initiatives are being adopted across academic institutions, workplaces and other public spaces at increasing rates. Yet, people recovering from SUDs are still a major group who are being overlooked and left out.

Beginning in the 1970's, researchers and educators saw a need to provide an academic community supportive of the specific needs of students in recovery. From this, Recovery High Schools and Collegiate Recovery Communities were founded across the nation. These institutions seek to build a student's recovery capital by encouraging connectedness and healthy social ties to their peers and the community around them. They are unique in that they offer a student in recovery the academic, therapeutic, and social resources necessary for achieving and maintaining sobriety as they seek their high school or college level degree.

[72] Finch et al., 2018
[73] Cleveland et al., 2010

Recovery High Schools (RHSs) are for teenagers recovering from chemical dependencies. Evidence from a study conducted on a number of RHSs found a significant difference where students who completed SUD treatment programs and had attended RHSs were still sober 6 months following subject recruitment to the study. The study population was compromised of adolescents who attended RHSs for at least 28 days after intake to the study.[74] Besides higher achieved and maintained sobriety rates, what was also statistically significant were differences in levels of marijuana use and absenteeism, which were lower for RHS students than non-RHS students. A study conducted by David L. Weimer examined the cost-effectiveness of RHSs. It was concluded that despite their higher administrative costs due to lower teacher-student ratios and increased treatment costs due to higher rates of participation in treatment programs, RHSs still offer more positive cost-benefits than non-RHS programs. When the increased probability of graduating from high school was monetized, “Mean net benefits ranged from $16.1 thousand to $51.9 thousand per participant; benefit-to-cost ratios ranged from 3.0 to 7.2”.[75] Compare this to results from the Washington State Institute for Public Policy (WSIPP) who found net benefit of SUD standalone treatment, “ranging from negative $5,827 to positive $2,370 for youth substance abuse treatment.” This was only for 12 months following the program. The continued cost benefits over a lifetime with reduced costs due to recovery from SUDs offer further positive cost benefits to society overall.[76]

At the collegiate level, the equivalent to a RHS would be a **Collegiate Recovery Program** (**CRP)** or **Collegiate Recovery Community (CRC)**. Many different models of what this looks like have been tried nationwide, from fully immersive programs where all students are people in recovery, to integrated programs which offer CRCs for students either on or off-campus in the midst of others who are not dealing with a SUD. From the first CRC founded by Dr. Bruce Eliot Donovan at Brown University in 1977, there are now 138 CRCs in the US[77]. The programs at Rutgers University and Texas Tech University have the two most famous models for these types of programs.

Substance Abuse Recovery in College: Community supported abstinence by Kitty S. Harris and Richard Wiebe explain the features of such an approach in their book. Collegiate recovery communities often have these components:
[78]

- Peer-based tutoring among members of recovery community to enhance academic success
- Supervised residence on or off-campus, some unsupervised
- Program to match recovery community members with each other even for off-campus housing
- Mandatory and some optional participation in support services like community meetings and sessions with certified substance abuse counselors; residential social contracts for adherence to community rules; peer government systems for reviewing behavioral/contractual violations, updating behavior contracts;
- Administrative interaction with the university has been done at 3 different levels so far: "(1) student health services (e.g., the ADAPS program at Rutgers), (2) student services or campus life (e.g., the StepUP Program at Augsburg), or (3) an academic college or

[74] Finch et al., 2018
[75] Weimer et al., 2019
[76] Weimer, et al., 2019
[77] (Pennelle, 2019)
[78] Cleveland et al, 2010

department (e.g., the CSAR, now CCRC)." (Cleveland et al., p. 15)

Besides these supports, the researchers found the most impactful factor to the success of a student in recovery was the presence of a social network consisting of substance abstinent peers. As a result, colleges with CRCs often saw very low relapse rates, such as Texas Tech's 4.4%. Many of these programs also focus on equipping their students with tactics to maintain sobriety even outside of abstinent-friendly environments.

High schools, colleges, and universities who enact these programs for their students have displayed significant successes. Higher sobriety rates and lower instances of relapse of course translate into less medical costs incurred privately and publicly. Many CRC's boast higher GPAs for their students compared to the general student body, as well as higher graduation rates meaning students of these programs have better future job opportunities post-matriculation.[79] These communities are beneficial at the human level for the peer-support they offer participants as well as the SEL learning that is built into these curricula. This means students are coming out of these programs with great practice in healthy social skills and coping methods that should keep them moving forward on their road to recovery. This is a net positive benefit to society. Providing opportunities for people in recovery to seek and earn degrees while they are in their recovery process is not only a good cause to support, but it is also promoting equity.

Recommendations

For YPR, this cause is held in the same spirit as harm reduction and the Housing First model, that certain resources shouldn't be withheld from a person because they may still be actively using, nor should they be denied access to that until they can satisfy a clinician's definition of "sober". That they should not be ostracized, but be provided support as they achieve and maintain sobriety during their pursuit of positive goals like higher education. In order for this to happen, stakeholders must:

- Invest in expanding existing RHSs and CRCs in stakeholder's target area, or provide funding to found new ones in areas where the highest need has been assessed.
- Sponsor the funding of more research on the cost benefits of RHS and CRCs. Many of the limitations of past or current studies have attempted to investigate this, but often run into difficulties associated with forming a representative sample from the limited population they have to work with.
- Promote Social Emotional Learning (SEL) focus in curriculum. RHS study where participants self-reported their balance of academic rigor of their coursework and therapeutic support they received in their RHS.
- Most studies find the demographic for young people who get to participate in academic recovery communities are often White and of higher SES. Encourage/fund outreach to young people who come from marginalized communities such as low-income SES and communities of color so they can have better access to these types of programs as well.
- These institutions often come with sobriety stipulations, where YPR would like to see organizations with those barriers removed.
    - Fund services where coursework can be brought to students while they are in treatment, or can access online, or policies where they get a medical excuse to have their coursework essentially "paused" while they are in treatment and it does not count against their academic record. Then they simply "resume" the course the next semester it becomes available for enrollment following their

[79] Cleveland et al, 2010

successful exit from a treatment program.
- There needs to be more studies conducted that offer medication-assisted recovery to remove the sobriety barrier.

CALL TO ACTION

The research has highlighted the best practices for reducing harmful effects of substance use would be to support more expansive laws and policies which open access and remove barriers. This is true for medications which save people from preventable accidental overdoses and aid in recovery.

Experts believe it is vital to challenge the laws that continue to keep Safe Consumption Sites out of the United States. The data from these sites have proven to be cost saving and protects and fosters public safety. Stable housing should be provided for those not yet identifying in recovery. Experts have noted this has also proven to have overall positive effects that save taxpayers money.

Substance use does not end in incarceration.For those in recovery (or initiating recovery) while incarcerated, data has shown that programs which prioritize recovery over punishment are more cost-effective and successful than punitive measures. The success of the program is critically dependent on the nature of the offender's interaction with law enforcement and the supportive environment. This is a public health problem not a criminal issue. Advocates should highlight these programs and cost saving measures to policymakers.

Recognizing that recovery is something that needs to be accomplished systemically with long-term disease management instead of acute treatment programs. This would require a small but crucial overhaul of healthcare systems which would be costly early on, however would be saving taxpayer dollars and hospital debts in the long term.

The population of students in high schools or on college campuses who need specialized support as they work towards their degrees is a group often overlooked for accommodations in these environments. Recognizing them would make campuses more equitable and provide spaces that foster growth and development that is regarded at the collegiate level. Experts note academic recovery communities are vital to the success of these students and should be sufficiently funded. The loud cry for more research to be conducted on aspects presented for all five pillars must be answered.

DATA

Figure 1
(YPR Program Department data, accessed 07/11/2021)

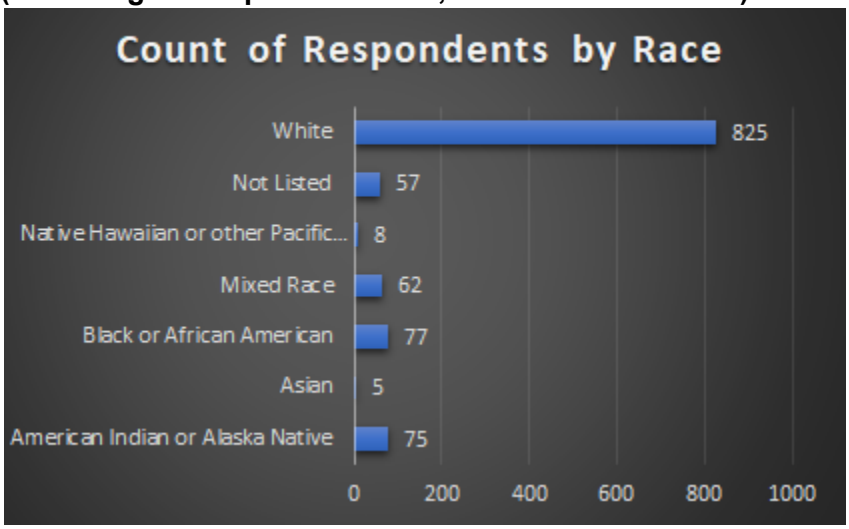

Figure 2
(YPR Program Department data, accessed 07/11/2021)

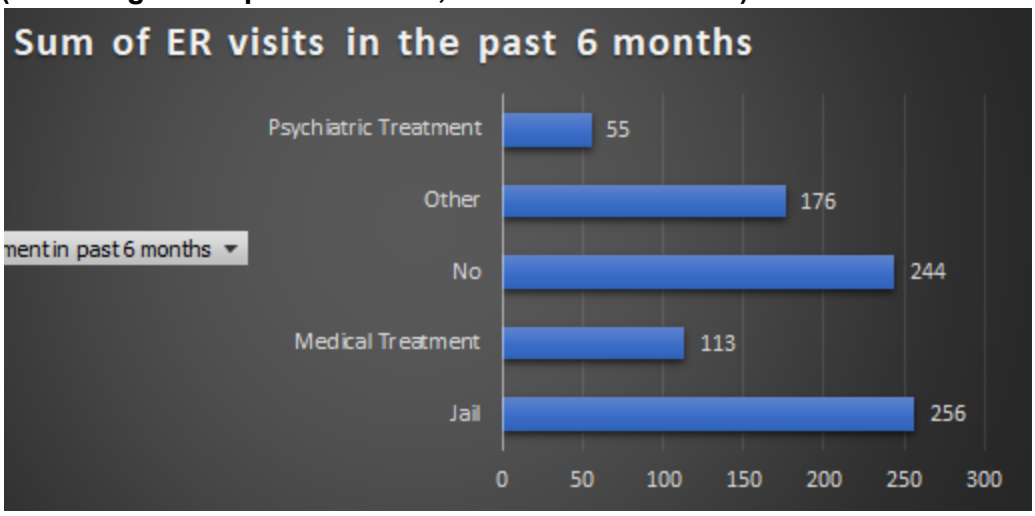

Figure 3
(YPR Program Department data, accessed 07/11/2021)

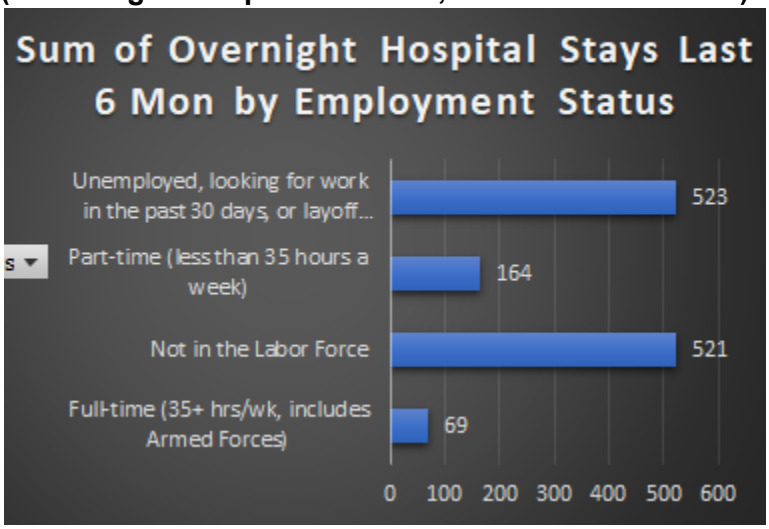

Figure 4
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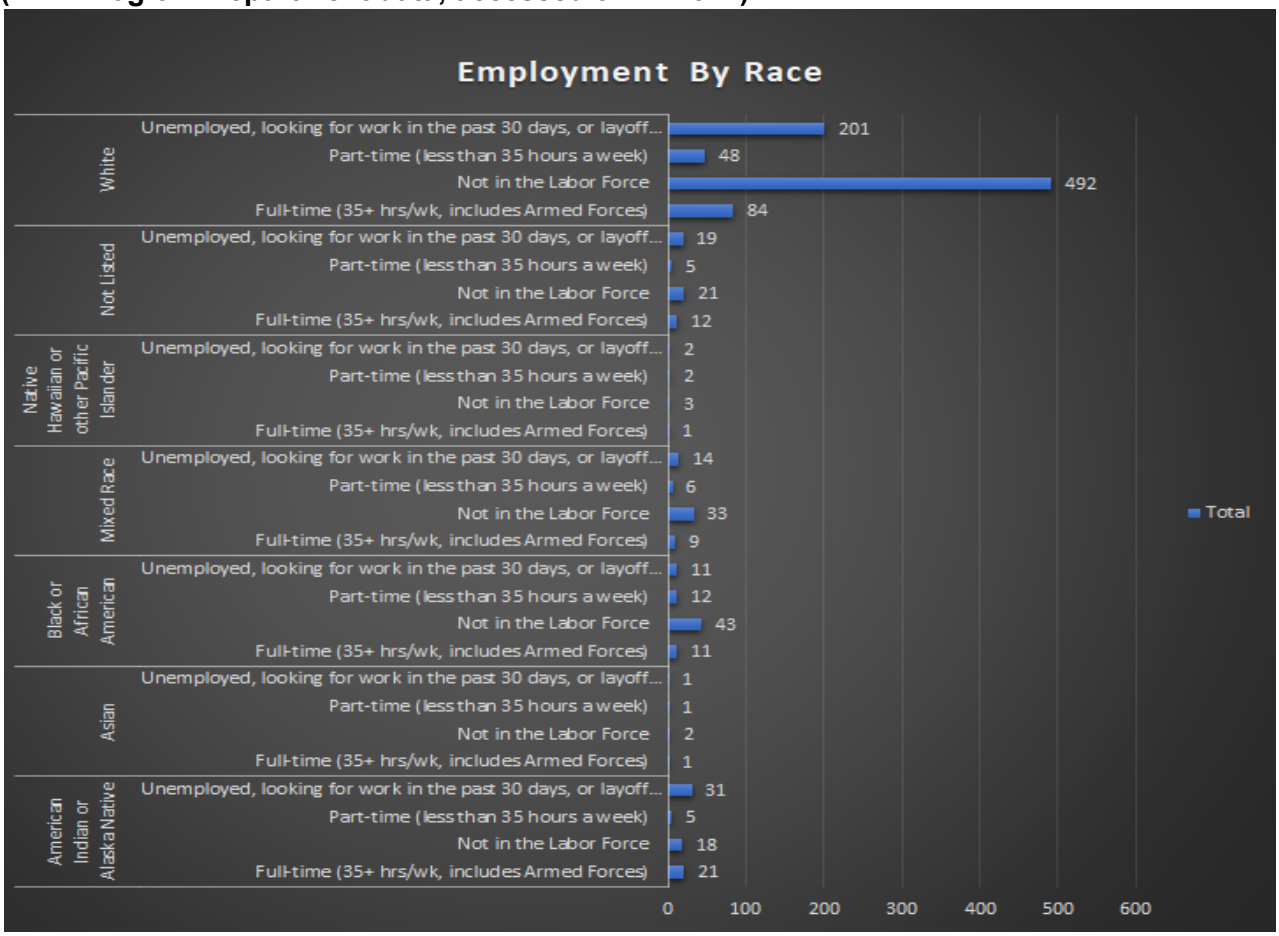

Figure 5
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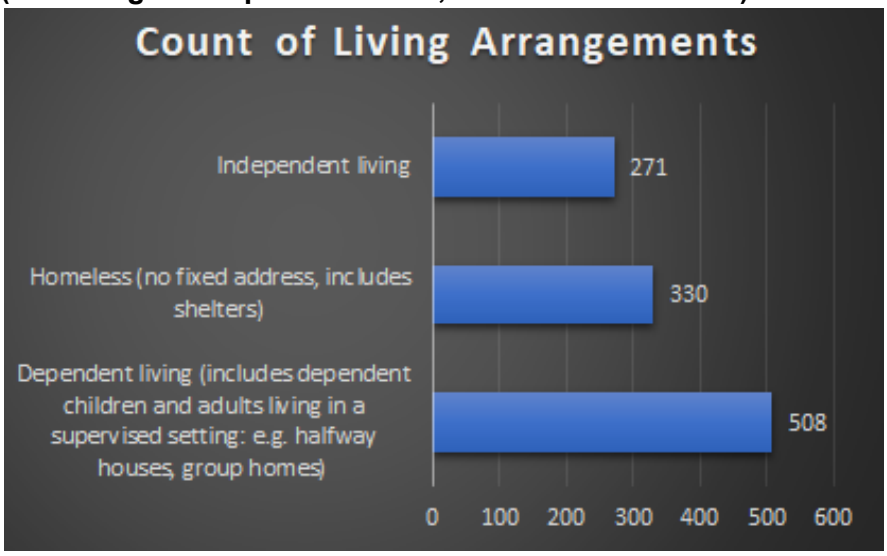


FIgure 6
(YPR Program Department data, accessed 07/11/2021)

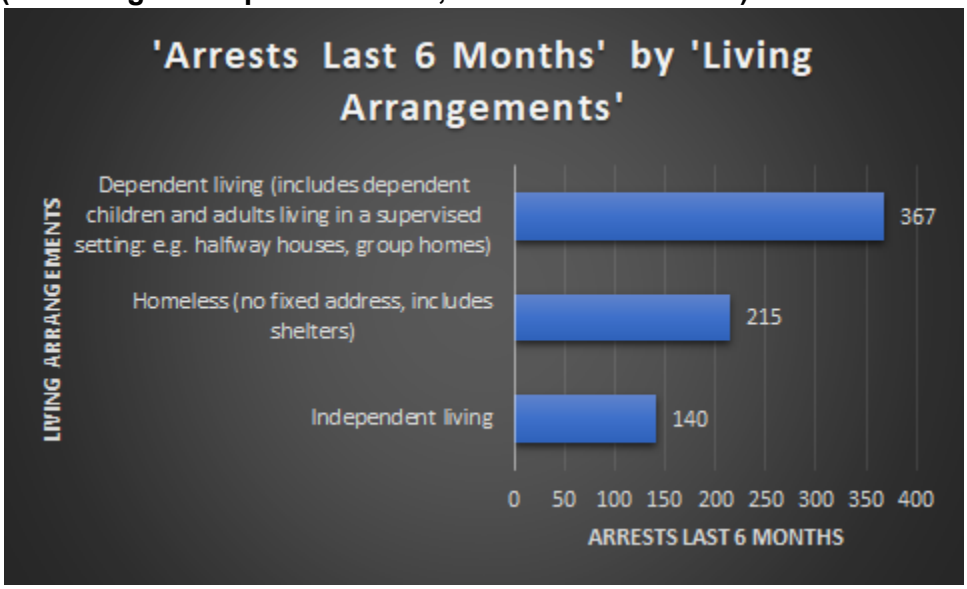


Figure 7
(YPR Program Department data, accessed 07/11/2021)

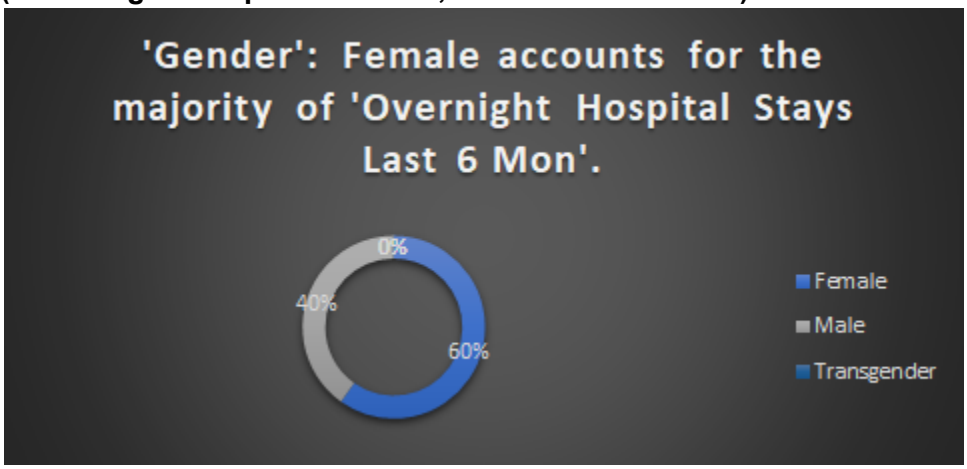


Figure 8
(YPR Program Department data, accessed 07/11/2021)

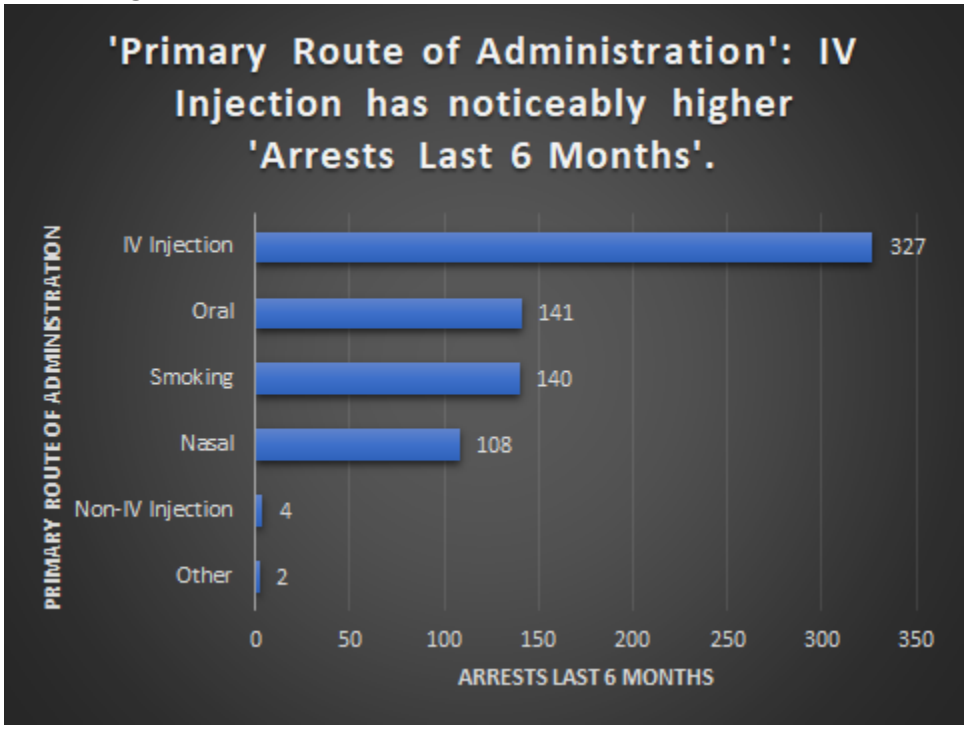


Figure 9
(YPR Program Department data, accessed 07/11/2021)

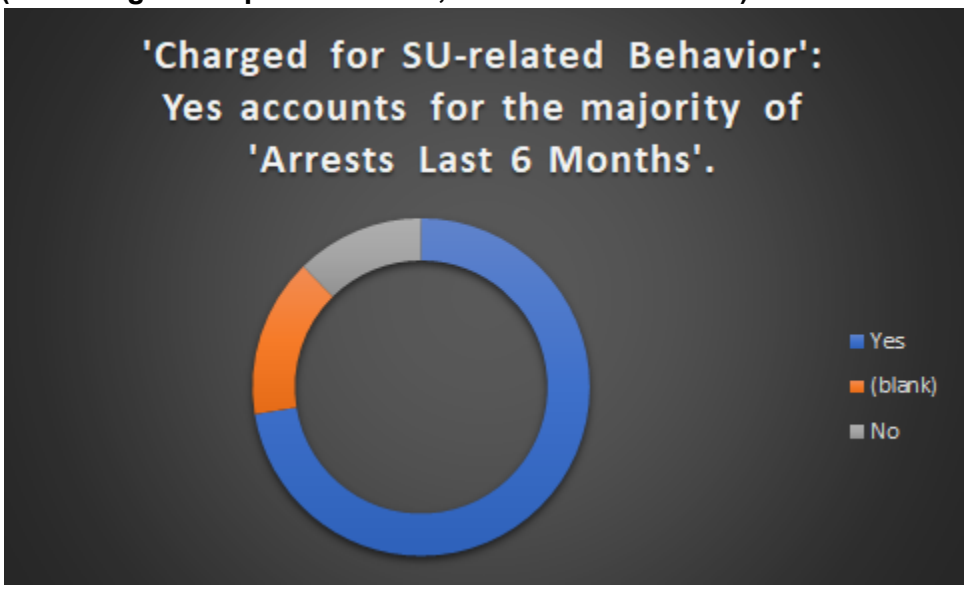


Figure 10
(YPR Chapter Department, Census, accessed 07/2021)

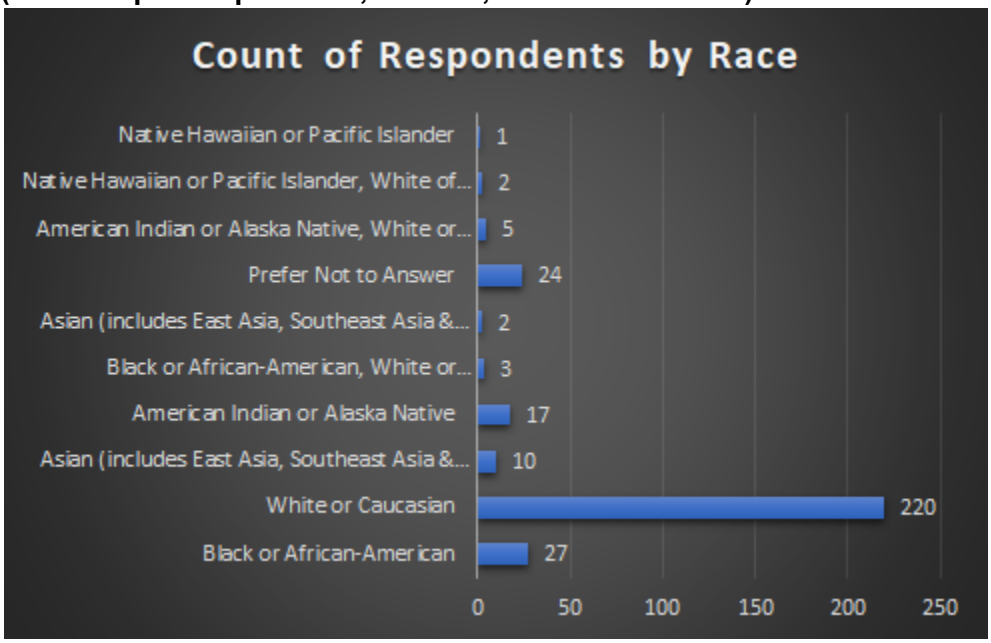


Figure 11
(YPR Chapter Department, Census, accessed 07/2021)

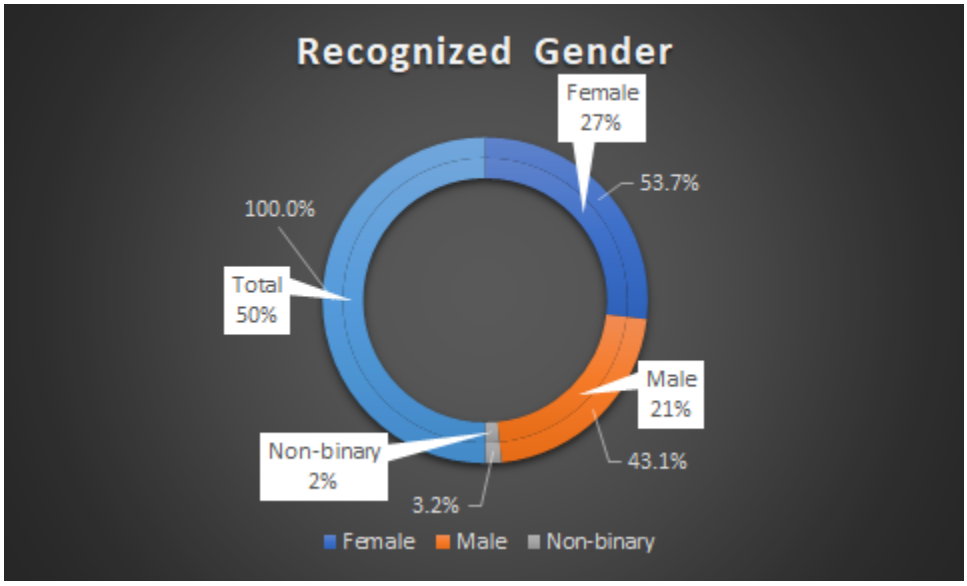


Figure 12
(YPR Chapter Department, Census, accessed 07/2021)

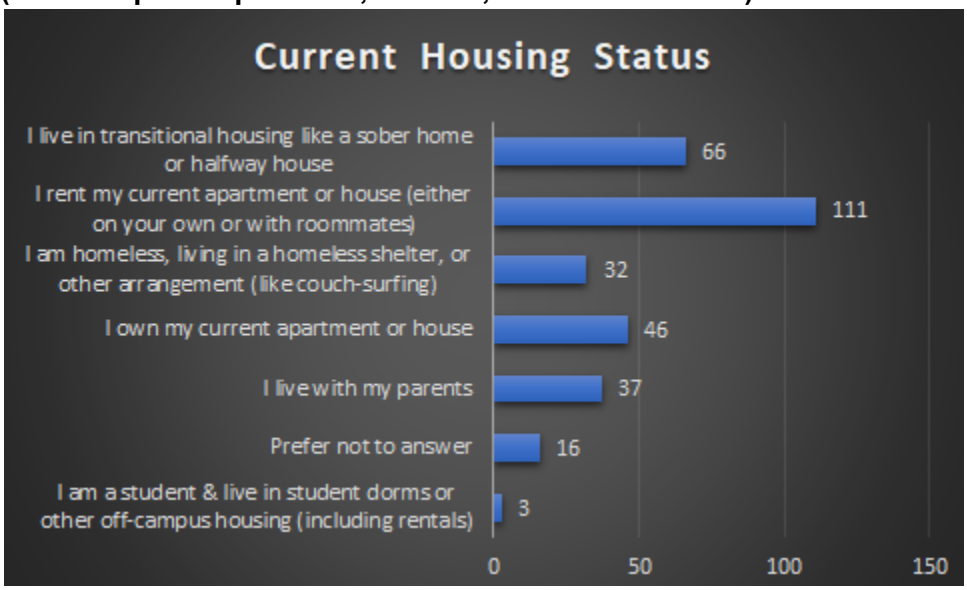


FIgure 13
(YPR Chapter Department, Census, accessed 07/2021)

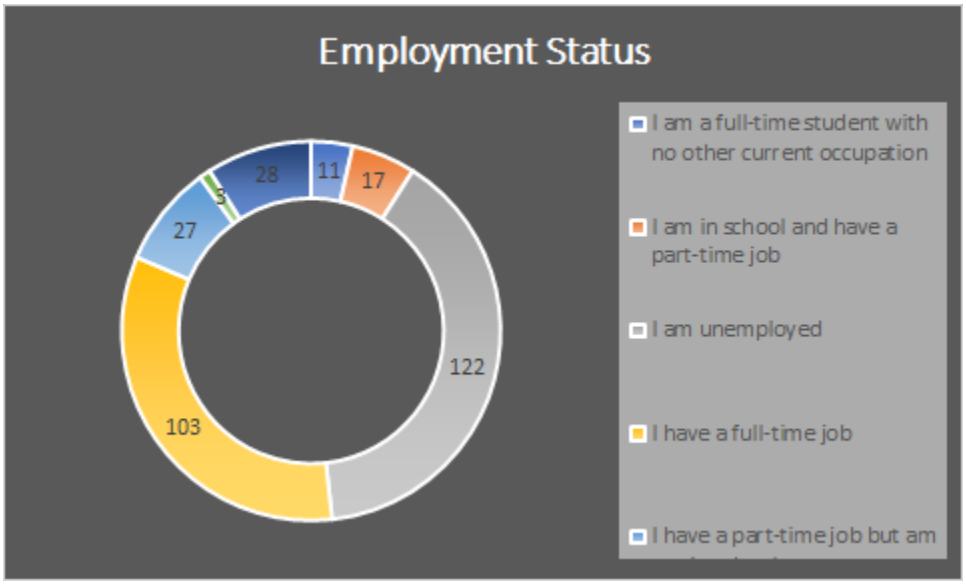


Figure 14
(YPR Chapter Department, Census, accessed 07/2021)

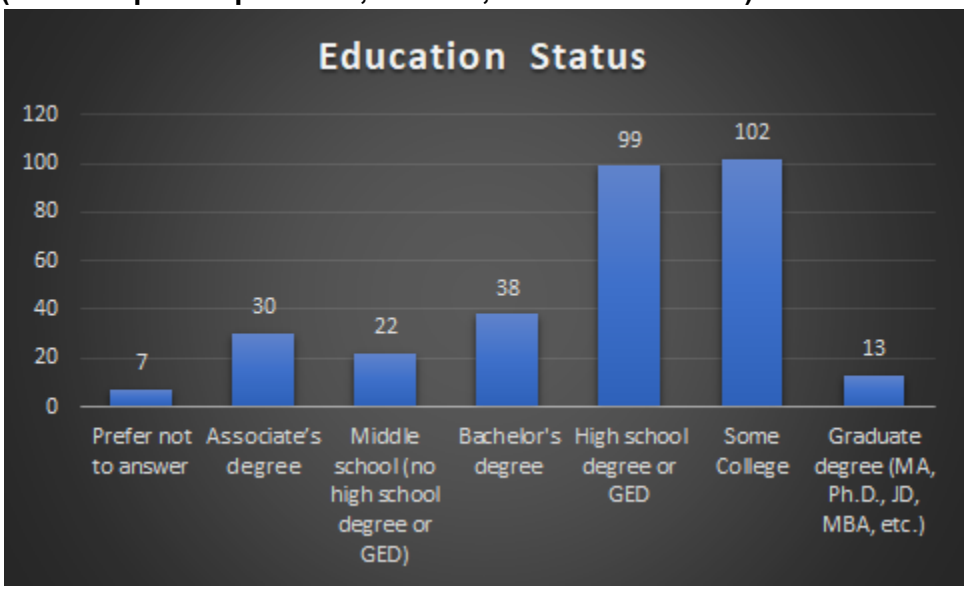


Figure 15
(YPR Chapter Department, Census, accessed 07/2021)

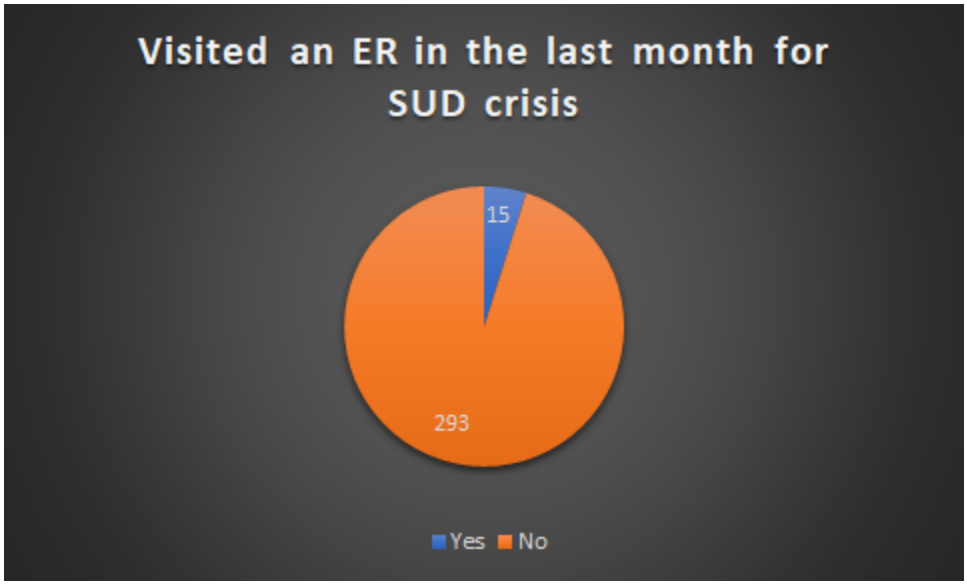


Figure 16
(YPR Chapter Department, Census, accessed 07/2021)

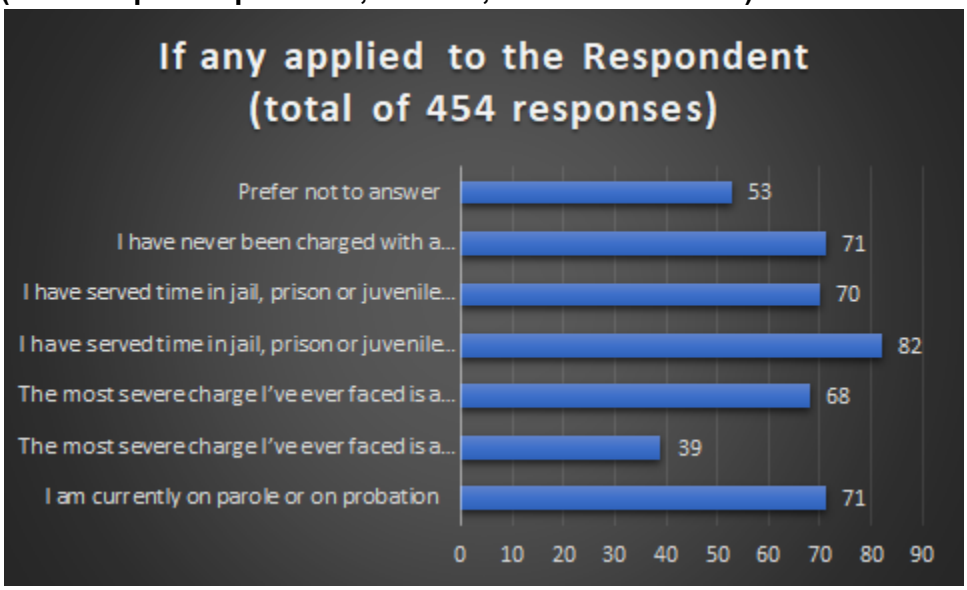
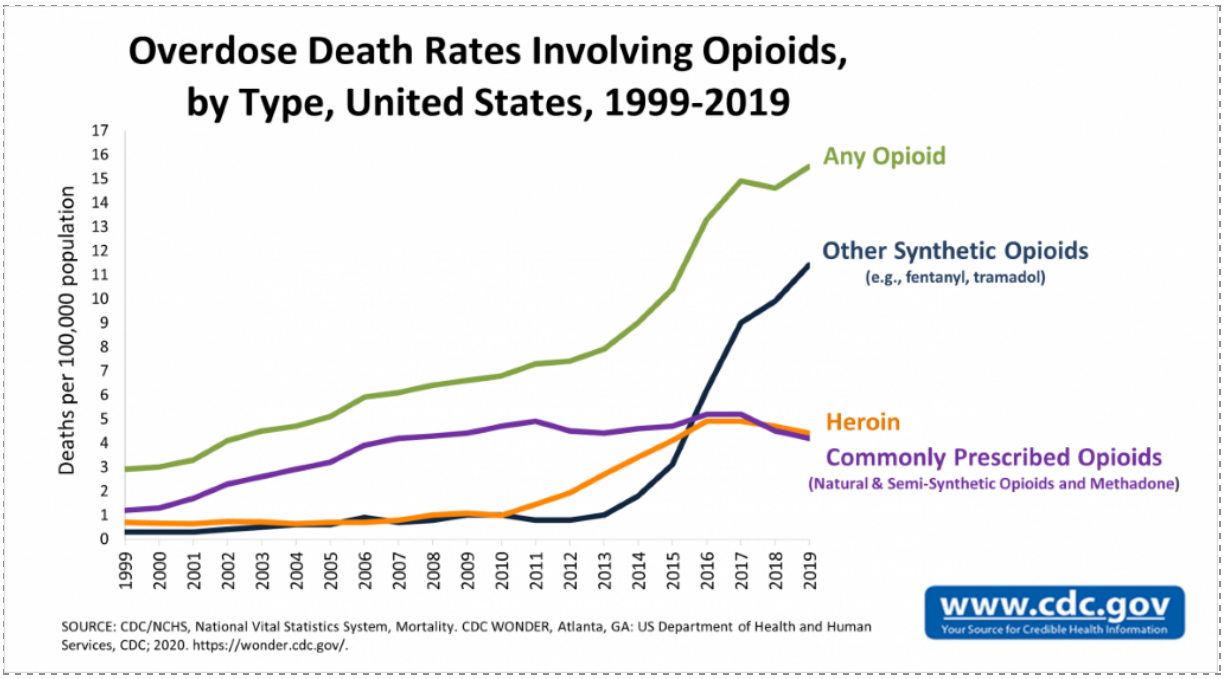


Figure 17
(Center for Disease Control and Prevention, 2020)



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(Center for Disease Control and Prevention, 2021)

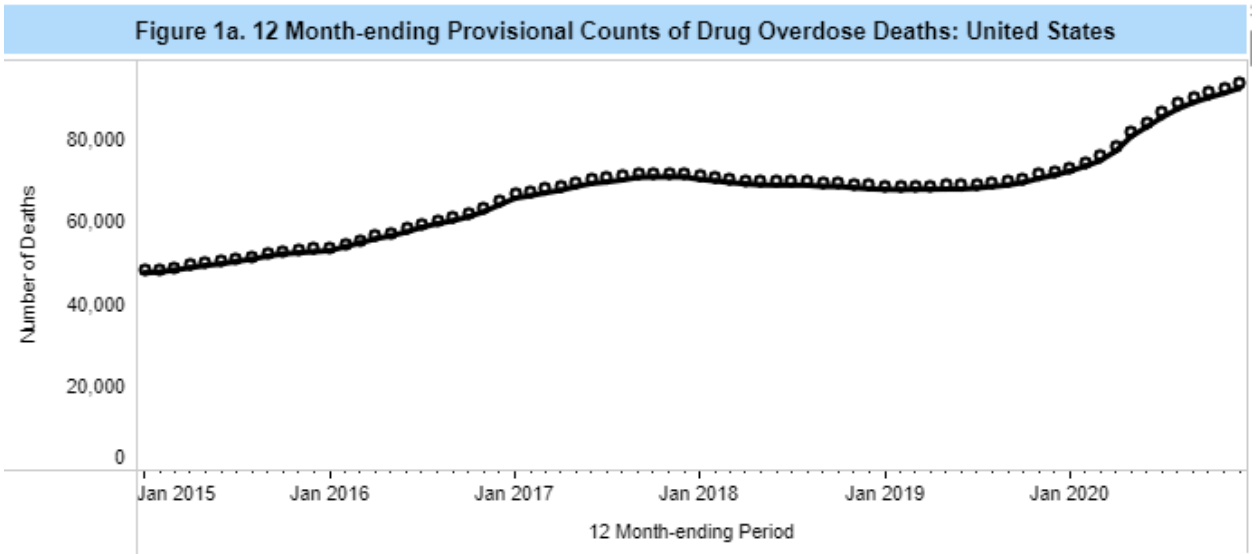


Figure 19
(Center for Disease Control and Prevention, 2021)

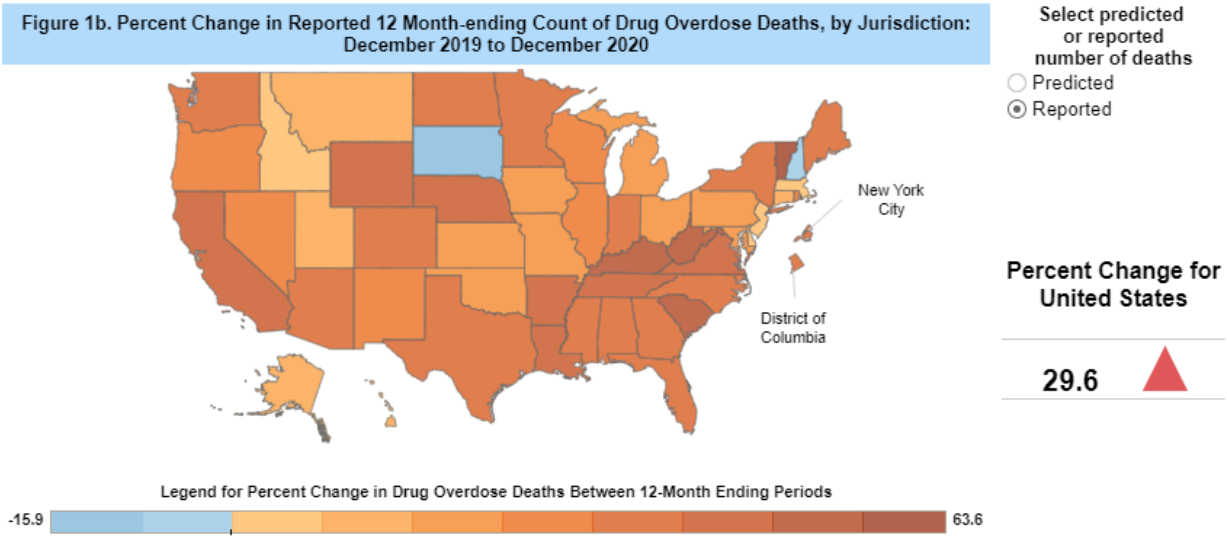
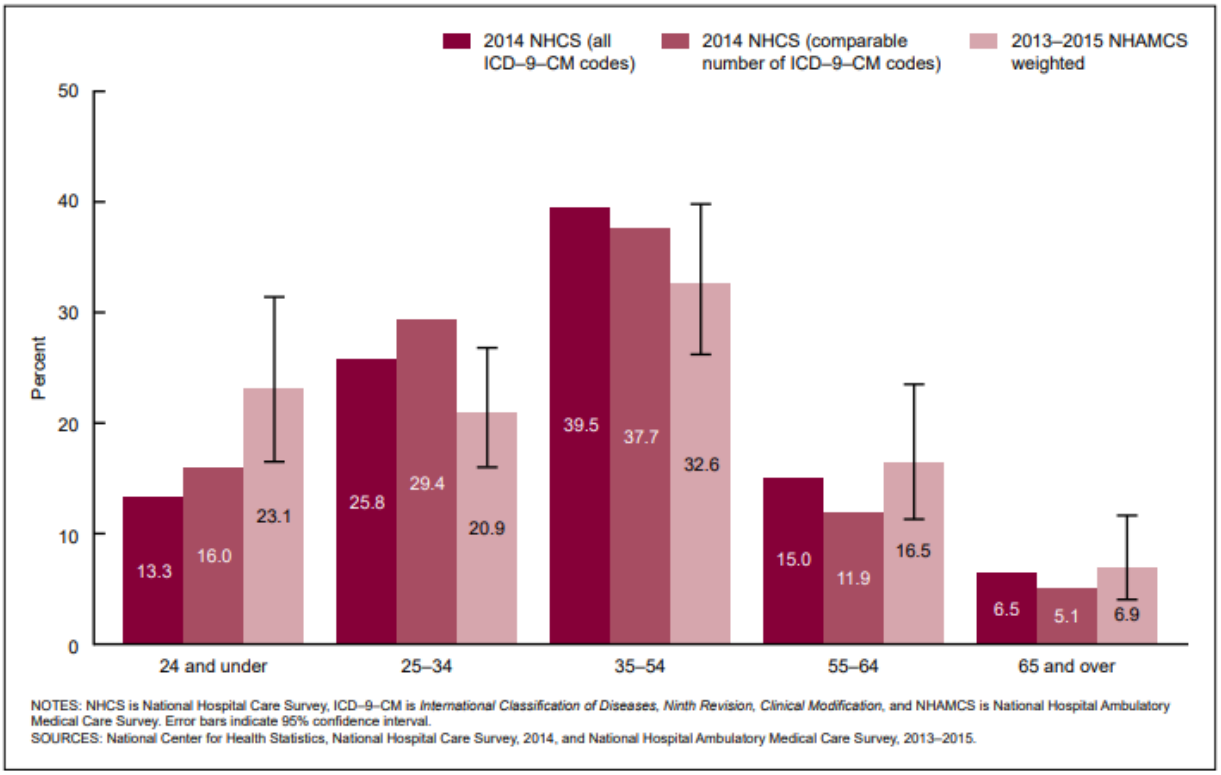


Figure 20
(Jackson et al., 2020, 4)

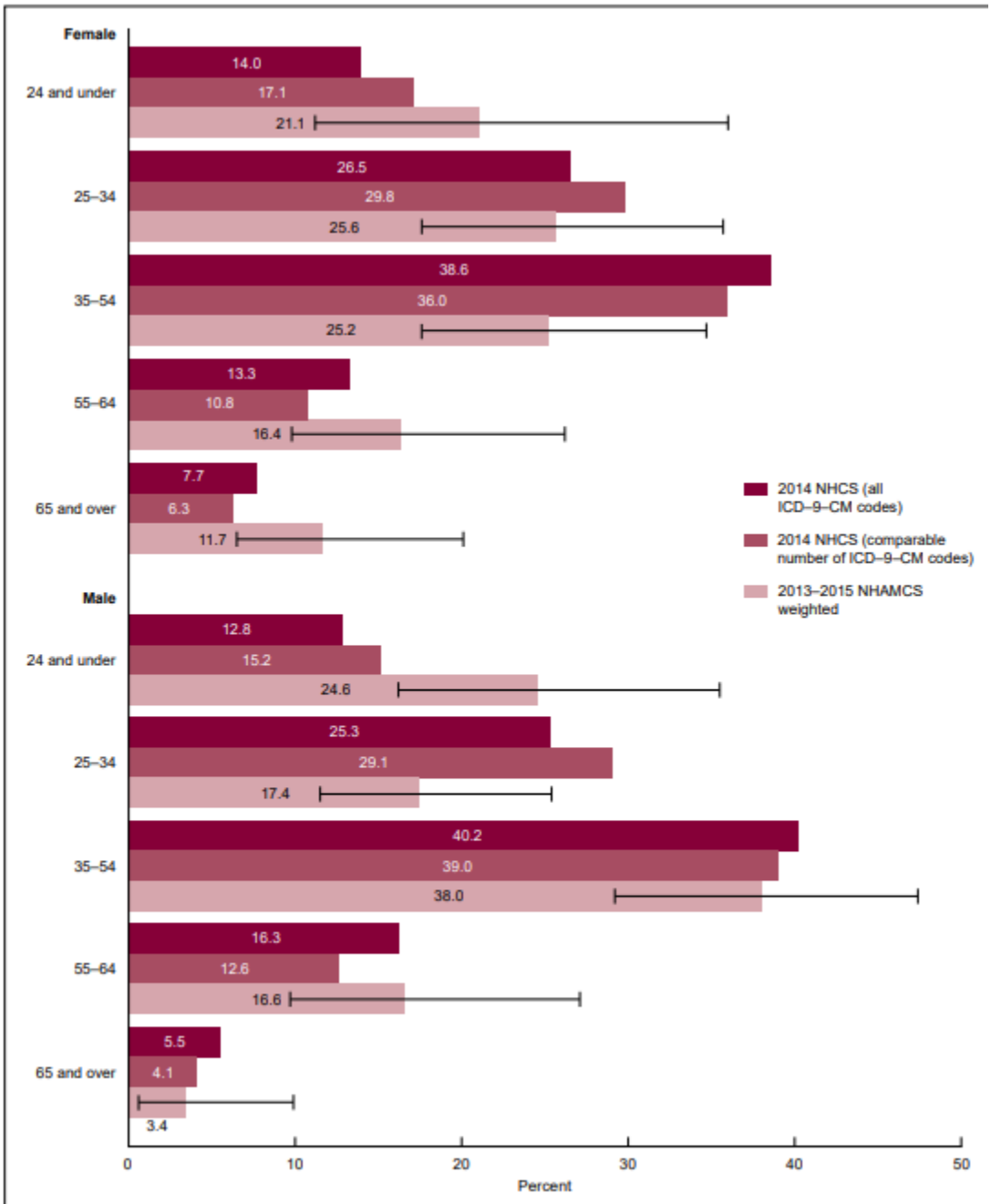
Figure 1. Age distribution of opioid-involved emergency department visits: National Hospital Care Survey, 2014, and National Hospital Ambulatory Medical Care Survey, 2013–2015



NOTES: NHCS is National Hospital Care Survey, ICD–9–CM is *International Classification of Diseases, Ninth Revision, Clinical Modification*, and NHAMCS is National Hospital Ambulatory Medical Care Survey. Error bars indicate 95% confidence interval.
SOURCES: National Center for Health Statistics, National Hospital Care Survey, 2014, and National Hospital Ambulatory Medical Care Survey, 2013–2015.

Figure 21
(Jackson et al., 2020, 6)

Figure 3. Age distribution of opioid-involved emergency department visits, by sex: National Hospital Care Survey, 2014, and National Hospital Ambulatory Medical Care Survey, 2013–2015



NOTES: NHCS is National Hospital Care Survey, ICD–9–CM is *International Classification of Diseases, Ninth Revision, Clinical Modification*, and NHAMCS is National Hospital Ambulatory Medical Care Survey. Error bars indicate 95% confidence interval.
SOURCES: National Center for Health Statistics, National Hospital Care Survey, 2014, and National Hospital Ambulatory Medical Care Survey, 2013–2015.

Figure 22
(U.S. Government Accountability Office, 2021)

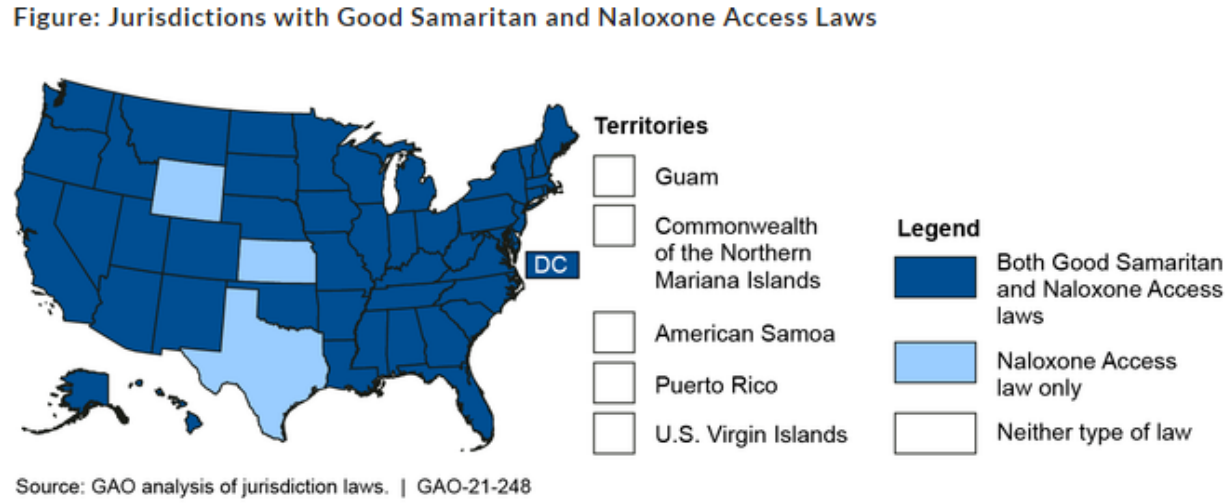
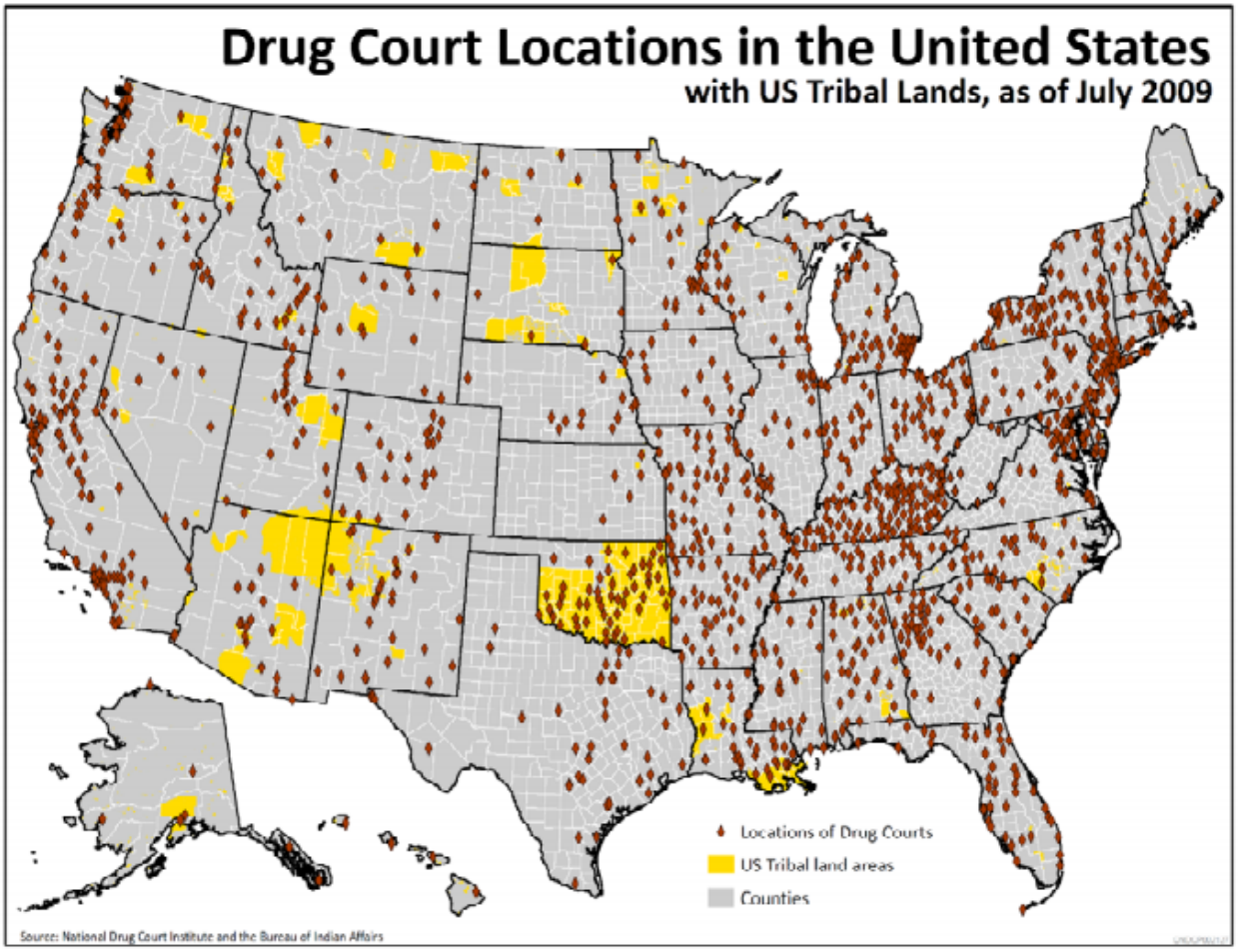


Figure 23



Source: National Drug Court Institute and the Bureau of Indian Affairs

Figure 24
(Source: Federal Office of Justice Programs)

DISTRIBUTION OF SAMPLE BY DRUG COURT CHARACTERISTICS (N=95)		
	Percentage Unweighted	Percentage Weighted
Number of graduates (thru July 1, 2001)		
< 50	2.7%	1.1%
51-99	6.4	4.3
100-249	32.9	31.4
250-499	26.6	14.2
>499	31.3	49.0
Number of annual graduates (estimated)		
< 50	9.9%	3.1%
51-99	20.1	9.5
100-249	44.0	31.1
250-499	20.5	31.0
>499	5.6	25.3
Date Court Opened		
1989-1994	32.7%	36.8%
1995	19.1	9.4
1996	19.4	14.3
1997	24.5	32.9
1998	4.3	6.6
Date of graduation		
January–March, 1999	33.4%	39.7%
April–June, 1999	27.3	29.3
July–September, 1999	14.0	12.2
October–December, 1999	8.3	6.6
January, 2000–	17.1	12.3

Figure 25
(Centers for Disease Control and Prevention, 2021, p. 55)

Table 11. Estimated HIV prevalence among White persons aged ≥13 years, by year, sex at birth, and selected characteristics, 2015–2019—United States *(cont)*

	Persons living with diagnosed or undiagnosed HIV infection					Persons living with diagnosed HIV infection			
	No.	RSE (%)	95% CI	Rate[a]	95% CI	No.[b]	%	RSE (%)	95% CI
	2019								
Male									
Age group (yr)									
13–24	5,200	5.7	4,700–5,800	38.0	33.7–42.2	3,050	58.3[f]	5.7	52.4–65.6
25–34	35,500	1.8	34,200–36,700	277.0	267.2–286.8	25,057	70.7	1.8	68.2–73.2
35–44	44,600	1.3	43,400–45,700	375.9	366.3–385.5	36,841	82.7	1.3	80.6–84.8
45–54	75,000	0.8	73,800–76,200	597.1	587.3–606.9	69,149	92.2	0.8	90.7–93.8
≥55	133,800	0.7	131,900–135,700	405.2	399.3–411.0	128,599	96.1	0.7	94.8–97.5
Transmission category[c]									
Male-to-male sexual contact	239,600	0.7	236,100–243,000	—	—	215,558	90.0	0.7	88.7–91.3
Injection drug use	15,800	3.5	14,800–16,900	—	—	13,411	84.7	3.5	79.3–90.9
Male-to-male sexual contact and injection drug use	25,000	2.3	23,900–26,200	—	—	22,774	91.0	2.3	87.1–95.3
Heterosexual contact[d]	12,500	3.7	11,600–13,400	—	—	9,922	79.1	3.7	73.8–85.3
Subtotal[e]	294,000	0.7	290,100–298,000	349.9	345.3–354.6	262,696	89.3	0.7	88.2–90.6
Female									
Age group (yr)									
13–24	970	12.8	730–1,200	7.4	5.6–9.3	551	56.8	13.7	45.4–75.9
25–34	5,700	4.3	5,200–6,100	45.8	41.9–49.7	4,007	70.8	4.4	65.3–77.4
35–44	9,100	2.7	8,600–9,600	77.6	73.5–81.8	7,607	83.7	2.8	79.5–88.5
45–54	12,300	2.1	11,800–12,800	97.5	93.5–101.5	11,294	92.0	2.1	88.3–95.9
≥55	16,600	2.0	15,900–17,200	44.0	42.3–45.7	15,772	95.2	2.0	91.6–99.0
Transmission category[c]									
Injection drug use	14,200	3.1	13,400–15,100	—	—	12,538	88.1	3.1	83.1–93.8
Heterosexual contact[d]	29,900	1.9	28,800–31,100	—	—	26,295	87.8	1.9	84.6–91.3
Subtotal[e]	44,600	1.6	43,100–46,000	51.0	49.4–52.7	39,231	88.0	1.7	85.3–91.0
Total[e]	**338,600**	**0.6**	**334,400–342,800**	**197.6**	**195.1–200.0**	**301,927**	**89.2**	**0.6**	**88.1–90.3**

Abbreviations: RSE, relative standard error; CI, confidence interval; CDC, the Centers for Disease Control and Prevention [footnotes only]; CD4, CD4+ T-lymphocyte count (cells/μL) or percentage [footnotes only].

Note. Estimates for the year 2019 data are preliminary and based on deaths reported to CDC through December 2020. Estimates derived by using HIV surveillance and CD4 data for persons aged ≥13 years at diagnosis. Estimates rounded to the nearest 100 for estimates of >1,000 and to the nearest 10 for estimates of ≤1,000 to reflect model uncertainty.

[a] Rates are per 100,000 population. Rates are not calculated for transmission category because of the lack of denominator data.

[b] Reported to the National HIV Surveillance System.

Figure 26
(Centers for Disease Control and Prevention, 2021, p. 54)

Table 10. Estimated HIV prevalence among Hispanic/Latino persons aged ≥13 years, by year, sex at birth, and selected characteristics, 2015–2019—United States *(cont)*

	Persons living with diagnosed or undiagnosed HIV infection					Persons living with diagnosed HIV infection			
	No.	RSE (%)	95% CI	Rate[a]	95% CI	No.[b]	%	RSE (%)	95% CI
	2019								
Male									
Age group (yr)									
13–24	11,700	4.3	10,700–12,700	191.4	175.2–207.6	5,959	50.8[f]	4.3	46.8–55.5
25–34	56,000	1.6	54,200–57,700	1,124.0	1,089.1–1,158.8	37,263	66.6	1.6	64.6–68.7
35–44	56,100	1.2	54,700–57,500	1,257.8	1,226.9–1,288.6	45,871	81.8	1.3	79.8–83.8
45–54	59,500	1.0	58,400–60,700	1,657.7	1,625.5–1,689.8	54,154	91.0	1.0	89.2–92.8
≥55	59,900	1.1	58,700–61,200	1,330.9	1,303.5–1,358.4	56,959	95.1	1.1	93.1–97.1
Transmission category[c]									
Male-to-male sexual contact	186,800	0.9	183,600–189,900	—	—	150,046	80.3[f]	0.9	79.0–81.7
Injection drug use	20,700	2.7	19,600–21,800	—	—	19,436	93.9	2.7	89.2–99.1
Male-to-male sexual contact and injection drug use	15,200	2.7	14,400–15,900	—	—	13,730	90.6	2.7	86.1–95.7
Heterosexual contact[d]	20,300	2.7	19,200–21,400	—	—	16,704	82.2	2.7	78.1–86.9
Subtotal[e]	243,200	0.8	239,700–246,800	1,028.0	1,012.9–1,043.1	200,206	82.3[f]	0.8	81.1–83.5
Female									
Age group (yr)									
13–24	1,100	11.9	850–1,400	18.9	14.5–23.3	660	59.6	12.7	48.3–77.9
25–34	5,900	4.0	5,500–6,400	130.6	120.4–140.9	4,466	75.2	4.0	69.7–81.6
35–44	11,200	2.3	10,700–11,700	265.9	254.0–277.8	9,788	87.7	2.3	84.0–91.8
45–54	14,500	1.8	14,000–15,000	408.8	394.5–423.2	13,466	93.1	1.8	90.0–96.5
≥55	18,300	1.7	17,700–18,900	351.6	339.8–363.3	17,492	95.4	1.7	92.3–98.7
Transmission category[c]									
Injection drug use	10,300	3.3	9,800–11,000	—	—	9,804	95.1	2.9	89.2–100.0
Heterosexual contact[d]	40,500	1.6	39,200–41,700	—	—	35,871	88.6	1.6	85.9–91.4
Subtotal[e]	51,000	1.4	49,600–52,400	218.4	212.2–224.5	45,872	89.9	1.4	87.5–92.6
Total[e]	**294,200**	**0.7**	**290,400–298,100**	**625.8**	**617.6–634.0**	**246,078**	**83.6**[f]	**0.7**	**82.6–84.7**

Abbreviations: RSE, relative standard error; CI, confidence interval; CDC, the Centers for Disease Control and Prevention [footnotes only]; CD4, CD4+ T-lymphocyte count (cells/μL) or percentage [footnotes only].

Note. Hispanic/Latino persons can be of any race. Estimates for the year 2019 data are preliminary and based on deaths reported to CDC through December 2020. Estimates derived by using HIV surveillance and CD4 data for persons aged ≥13 years at diagnosis. Estimates rounded to the nearest 100 for estimates of >1,000 and to the nearest 10 for estimates of ≤1,000 to reflect model uncertainty.

[a] Rates are per 100,000 population. Rates are not calculated for transmission category because of the lack of denominator data.

[b] Reported to the National HIV Surveillance System.

Figure 27
(Centers for Disease Control and Prevention, 2021, p 49)

Table 9. Estimated HIV prevalence among Black/African American persons aged ≥13 years, by year, sex at birth, and selected characteristics, 2015–2019—United States *(cont)*

	Persons living with diagnosed or undiagnosed HIV infection					Persons living with diagnosed HIV infection			
	No.	RSE (%)	95% CI	Rate[a]	95% CI	No.[b]	%	RSE (%)	95% CI
	2019								
Male									
Age group (yr)									
13–24	20,800	2.9	19,600–22,000	579.1	546.5–611.6	11,732	56.5[f]	2.9	53.4–59.8
25–34	82,600	1.1	80,800–84,500	2,545.2	2,488.3–2,602.2	60,336	73.0	1.1	71.4–74.7
35–44	57,900	1.1	56,600–59,200	2,291.5	2,241.1–2,341.9	49,384	85.3	1.1	83.5–87.2
45–54	65,500	0.9	64,300–66,700	2,743.5	2,693.6–2,793.3	60,868	92.9	0.9	91.2–94.6
≥55	100,400	0.9	98,600–102,100	2,343.0	2,302.2–2,383.8	95,456	95.1	0.9	93.5–96.8
Transmission category[c]									
Male-to-male sexual contact	219,200	0.8	215,900–222,600	—	—	181,186	82.6[f]	0.8	81.4–83.9
Injection drug use	32,700	2.4	31,400–34,300	—	—	31,382	95.9	2.2	91.6–100.0
Male-to-male sexual contact and injection drug use	16,200	2.9	15,300–17,200	—	—	15,268	94.0	2.9	88.9–99.6
Heterosexual contact[d]	58,500	1.6	56,700–60,300	—	—	49,511	84.6	1.6	82.1–87.3
Subtotal[e]	327,200	0.7	323,000–331,400	2,040.6	2,014.4–2,066.9	277,776	84.9[f]	0.7	83.8–86.0
Female									
Age group (yr)									
13–24	3,500	6.4	3,100–4,000	101.1	88.3–113.8	2,137	60.4	6.5	53.7–69.1
25–34	18,100	2.2	17,300–18,800	551.4	527.5–575.3	13,989	77.5	2.2	74.3–81.0
35–44	32,600	1.3	31,800–33,500	1,169.1	1,138.9–1,199.3	29,132	89.3	1.3	87.0–91.6
45–54	43,300	1.1	42,400–44,200	1,595.3	1,561.9–1,628.6	40,571	93.7	1.1	91.8–95.7
≥55	54,600	1.1	53,400–55,800	966.7	946.1–987.3	51,398	94.1	1.1	92.2–96.2
Transmission category[c]									
Injection drug use	23,800	2.5	22,900–24,900	—	—	22,915	96.4	2.1	92.0–100.0
Heterosexual contact[d]	127,800	0.9	125,500–130,100	—	—	113,741	89.0	0.9	87.4–90.6
Subtotal[e]	152,100	0.9	149,600–154,700	848.6	834.2–863.1	137,227	90.2	0.9	88.7–91.8
Total[e]	**479,300**	**0.5**	**474,400–484,300**	**1,411.4**	**1,396.8–1,426.0**	**415,003**	**86.6**[f]	**0.5**	**85.7–87.5**

Abbreviations: RSE, relative standard error; CI, confidence interval; CDC, the Centers for Disease Control and Prevention [footnotes only]; CD4, CD4+ T-lymphocyte count (cells/μL) or percentage [footnotes only].

Note. Estimates for the year 2019 data are preliminary and based on deaths reported to CDC through December 2020. Estimates derived by using HIV surveillance and CD4 data for persons aged ≥13 years at diagnosis. Estimates rounded to the nearest 100 for estimates of >1,000 and to the nearest 10 for estimates of ≤1,000 to reflect model uncertainty.

[a] Rates are per 100,000 population. Rates are not calculated for transmission category because of the lack of denominator data.

[b] Reported to the National HIV Surveillance System.

Figure 28
(Center for Disease Control and Prevention, 2020)

There are currently 44 states and DC, 1 tribal nation, 1 territory and with a determination of need in place.

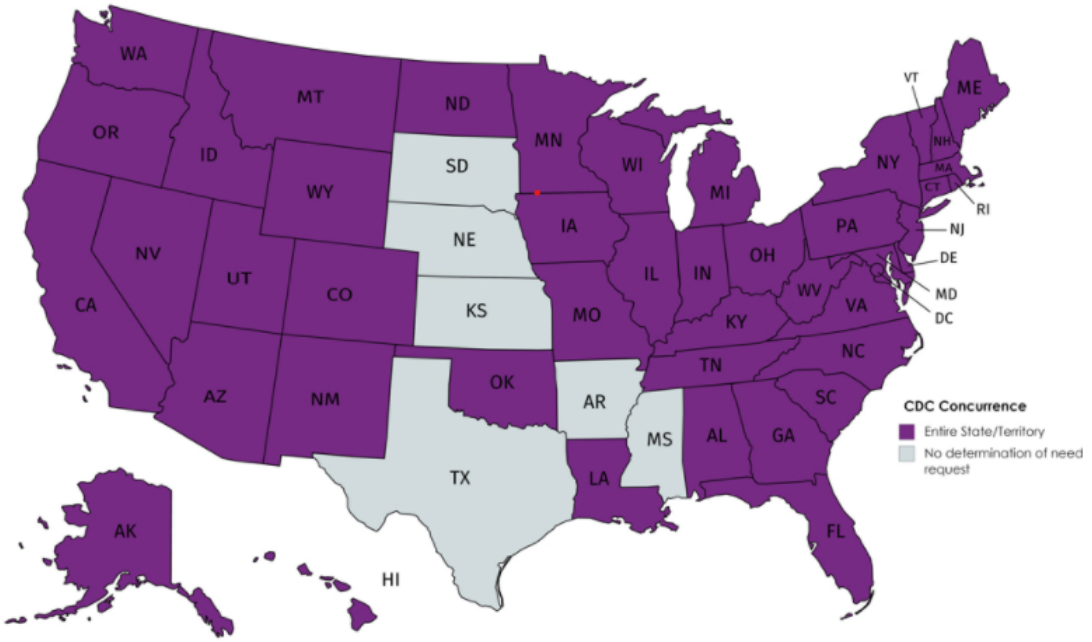


Figure 29
(Source: BJA and NDCI, 2011)

Drug Court Participants by Race

Race	Average (SD)	Range
White or Caucasian	62% (14%)	1% - 98%
Black or African-American	21% (28%)	1% - 95%
American Indian or Alaskan Native	4%	< 1% - 22%
Guamanian or Chamorro	3%	0% - 65%

GLOSSARY

A

Affordable Care Act (ACA): The comprehensive health care reform law enacted in March 2010 (sometimes known as ACA, PPACA, or "Obamacare").

C

Collegiate Recovery Program (CRP) or Collegiate Recovery Community (CRC): a College or University-provided, supportive environment within the campus culture that reinforces the decision to engage in a lifestyle of recovery from substance use.

Controlled Substances Act (CSA): The Controlled Substances Act (CSA) places all substances which were in some manner regulated under existing federal law into one of five schedules. This placement is based upon the substance's medical use, potential for abuse, and safety or dependence liability.

D

Disintegrative, or stigmatizing shaming: Social shaming tactic that ascribes negative labels to a person and their character.

Drug Court: a program designed to reduce drug use relapse and criminal recidivism among defendants and offenders through a variety of services.

G

Good Samaritan Laws: A state law protecting individuals who reasonably attempt to rescue or aid another; designed to encourage public acts of assistance.

N

Naloxone: Naloxone is a medicine that rapidly reverses an opioid overdose. It is an opioid antagonist.

P

Poly-use: 'Polydrug use' is a term for the use of more than one drug or type of drug at the same time or one after another.[1] Polydrug use can involve both illicit drugs and legal substances, such as alcohol and medications.

R

Recidivism: the tendency of a convicted criminal to reoffend.

Recovery capital: the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from severe AOD problems.

Reintegrative shaming: Social shaming tactic that denounces a person's actions, but not their character

Recovery High Schools (RHSs):
A secondary school for teens that are designed specifically for students in recovery from substance use disorder or co-occurring disorders

Recovery-Oriented Systems of Care:a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.

S

SES: Socioeconomic status

State Mandate Drug Treatment Program: program, which targets high risk, high needs offenders with a history of substance use as a crime-producing behavior leading to correctional supervision

SUDs: Substance use disorders

Syringe Services Programs (SSPs): are community-based prevention programs that can provide a range of services, including linkage to substance use disorder treatment; access to and disposal of sterile syringes and injection equipment; and vaccination, testing, and linkage to care and treatment for infectious diseases.can provide a range of services, including linkage to substance use disorder treatment; access to and disposal of sterile syringes and injection equipment; and vaccination, testing, and linkage to care and and treatment for infectious diseases.

Supervised consumption services (SCS), Safe Injection Sites (SISs) supervised injection facilities (SIFs): are harm reduction programs that offer a range of low-barrier services to people who use drugs, such as hygienic and supportive spaces for drug consumption, sterile drug using supplies, peer support, and ancillary health and social services.

W

Washington State Institute of Public Policy (WSIPP): The Washington State Institute for Public Policy (WSIPP) is a nonpartisan public research group located in Olympia, the hub of Washington State government.

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