Recovery Capitalists and the Industries of Dependency

We are at the 25th anniversary of the new recovery advocacy movement in America. A movement to elevate and expand recovery opportunities nationally. It began as a grassroot community vision that rose up across the county. It envisioned a more cohesive treatment and community-based recovery model. A system to expand beyond the acute and fragmented treatment system of the preceding era. They wanted to build a recovery-oriented process centered on healing individuals, families and whole communities impacted by severe substance use conditions. An inclusive array of authentically grounded recovery supports. A network of ordinary people in recovery helping others heal as the keystone to develop strong networks of recovery community capital.

While much was achieved, we have not accomplished that vision. It would be prudent to reflect and evaluate where we are at the crossroads we find ourselves standing in. To effectively help people in early recovery back into productive living, the capacity to assist in their recovery must include services for people who qualify for welfare, yet to get them out of welfare, services cannot end when we help a person off welfare to regain their productivity. This is why in an earlier era there were concerns about focusing on peer services housed primarily within a Medicaid billing framework with no way out. They realized that if we were not careful, we would develop models of care that fostered welfare dependency. It would end with yet another new profit-motivated industry of professionals that commodifies our recovery communities. Increasingly, that is what it has yielded. Now is the time to reorient to a recovery community grounded care system that can truly transform recovery in America.

A service mentality grounded in mutuality and autonomy was central to the originating vision of the movement, not a billable service provided by sanctioned professionals managed by an industry and its associated gatekeeping systems. Instead, they imagined Recovery Community Organizations (RCO)s run by and for people in recovery helping to heal their own neighborhoods in collaborative processes that valued and engaged everyone. Paid staff as well as volunteers of all walks of life engaged in efforts to help themselves by helping others. Care and support that fosters autonomy and the capacity of whole communities. Processes that bring people together to expand recovery capital in all its forms in all of our communities in all the diverse ways that it nurtures, grows and supports authentic community level healing.

Building these hives of recovery strengthening connections was the originating vision of the Recovery Community Support Project (RCSP) Grants through SAMHSA in the late 1990s. Grantee organizations attended the first national recovery summit in Saint Paul Minnesota, an event I have documented extensively, including interviews with key leaders to memorialize their insights into the event and what it meant for the birth of the movement. They went forth from Saint Paul to share the vision and make it a reality from coast to coast. They were the proverbial "little engine that could" as Bill White noted in his interview with me in 2021. A great deal of what we have accomplished to expand recovery opportunities over the years originated with these visionaries in that era of our history.

- They had goals as William White and Pat Taylor described in a New Recovery Advocacy Movement
- They had steering concepts as I described in The Keel of the New Recovery Advocacy Movement
- They elevated the concept of recovery capital and the role of community in healing as written about by Dr David Best et al in Recovery as a social phenomenon: what is the role of the community in supporting and enabling recovery
- Concerns were expressed as far back as 2013 about how singular focus on professional peer services as the primary goal of the movement would lead to failure by William White who expressed his concerns to the assembled leaders of the recovery movement at a Faces & Voices of Recovery event in Dallas Texas and then in a paper.

Within a short time span, the RCSP grants focus pivoted from support to a peer service orientation. This change occurred during a new federal administration. Over time, it also made a 180 degree turn from community oriented to embrace a professional peer service model. Two distinct models evolved. One was a recovery community organizations model of community centers run by and for people in recovery where anyone who walked in the door could find a way to be

involved, not just in their own recovery healing process, but to support others in mutual healing. This model preserved the focus on strengthening recovery community capital. It has never been systemically funded or supported. They have attempted with some limited success to use the billable peer model to support. Where it has been preserved, it is has been sustained in a patchwork fashion through the sheer determination of dedicated servant leaders across the nation.

The second model, which rapidly gained traction and is now the dominant paradigm is the fee for service peer recovery support service (PRSS) model. One provided by credentialed individuals to people in need via units of service to support their healing. It is oriented to the development of recovery capital on the level of the individual but less so in respect to community recovery capital. These services have increasingly become the primary manner in which recovery support is provided in America. A politically expedient strategy with consequences that are still unfolding.

Some groups have attempted to sustain broader missions of recovery community capital bridging models but find it increasingly difficult to do. The primary funding mechanism for peer services nationally is Medicaid. This has some profound drawbacks as people are people are largely barred from employment to be sustained on funding ostensibly intended to help them grow and heal. The interests of the provider and the recipient can in this way run in conflict.

As noted in the 2023 report from SAMHSA, Financing Peer Recovery Support: Opportunities to Enhance the Substance Use Disorder Workforce, the Consolidated Appropriations Act, 2023 allows for direct reimbursement of peer support specialists for mental health and SUD services. 48 of 50 states are providing Medicaid coverage for peer recovery support services (PRSS). It is the primary mechanism for funding peer recovery support services in the United States. All states have income limits for Medicaid eligibility, so there are ceilings to how much an individual or family can earn to sustain benefits. It can be a very beneficial resource that saves lives and helps people heal, but it can also be a trap for our people. We should be having broad and open dialogue about this.

Peer services are subsequently being professionalized to mirror clinical services as peer support is monetized and limited to narrow areas of focus in which the recipient is to derive prescribed benefits, and the provider gets reimbursed for dispensing and billing for them. It certainly has value, but it fails to derive mutuality in ways that expand community building and recovery capital bridging strategies that serve vital needs by engaging the community as the healing agent.

The Emerging Recovery Capitalists

Other groups unfortunately have seen the expansion of Medicaid funded and the industry of professionalized peer services as a "get rich quick" opportunity. They push overburdened and underpaid workers to provide as many billable services in a day as is possible. One that made headlines was the billing to taxpayers for 203 hours of work by one employee in a single day as made the news in Minnesota. It highlights how there are people who view those of us with substance use conditions are first and foremost a commodity to be monetized. When these kinds of things happen, as they have across our history, it harms us all, including many ethically operated and deeply dedicated organizations.

Similarly, the training and credentialing of these overburdened and underpaid workers seeking a place in the field are increasingly being seen as markets to corner and control. Easily justified in a negative feedback loop because of the inevitable fraud and abuse that occurs when people like the new recovery capitalist see vulnerable people as their meal ticket. We have moved away from a credentialing and training system run by and for communities of recovery to extend opportunities to help heal of their communities through service to others. Instead of pulling people in to foster broad efforts of positive change and growth, they become gatekeeper structures that as our history reveals gradually shifts into academic measures that serve to keep people in recovery who do not have the right secondary education out and to be monetized for the benefit of the credentialed few and those who train and credential these professionals.

Keeping People on Welfare and the Dynamics of Dependency

Keeping people in early recovery unemployed and on welfare is often dangerous for their recovery. As a matter of record, in every place I managed there was a focus of effort wherever possible to get people into employment and off of welfare. It was what they wanted. The vast majority of people I have worked with who had substance use conditions, wanted a job and a chance to get back on their feet so that they could take care of themselves and their families. They desired what former Editor in Chief, Dr. Eric Strain of the Journal Drug and Alcohol Dependence termed in a piece on meaning and purpose in the context of the opioid epidemic as "the opportunity to flourish." One of the things that should be occurring broadly across our field is a focus on whose interests are served by the manner our systems are funded. When providers have incentives to sustain access to welfare benefits to bill for services it can interfere with

recipient growth and autonomy. I am not hearing these conversations. We should embrace the ethos of recovery and make space for dialogue on these uncomfortable issues.

We know that in general people do better in substance use recovery when they are working. Sitting at home collecting a welfare check is a dangerous and debilitating prospect for many of us in early recovery. Boredom and lack of purpose are significant risks to sustained recovery. Helping people get back on their feet and to get a job so they can move forward with their dreams should be our end goal. Achieving this is a common source of pride for millions of us in recovery. It is also critical for policymakers to see that funding through welfare is a means to the end goal of productivity and not establish welfare dependency for an industry. It should also be recognized that many of us in recovery want this too. A chance to flourish through productivity.

While there are people with cooccurring mental health of physical conditions making it likely and rightfully so that they will get longer term Medicaid funding, there is also an emerging industry of peer services funded by Medicaid that risks keeping people from getting employed as this would interfere with the funding. If you think this is a stretch, consider again that overburdened and underpaid peer worker that is being pushed to bill a full day of services every day just to keep their jobs and the only source of funding they have is a Medicaid billing structure. There is an inherent conflict here. Keeping people on welfare and unemployed is in the interest of that overburdened and underpaid peer worker in order to keep their job and the program managers seeking to squeeze every hour of billable units. A dollar sign and a paycheck.

Two summers ago I wrote Highlight Social Movements End – So How Will Ours End. In it I noted that people and institutions are losing focus on the primary goals of the movement, shifting to other aims as funding and interest changes. Altered in no small part because we have forgotten our own history. We are at a crossroads, a time for great caution. As I wrote at that time, history is not linear. It is our movement to sustain or lose to history. Do we act with unity and integrity and "keep our eye on the prize" as Bill White urged a generation ago, or do we respond otherwise out of myopic self-interest and ultimately fail? The stakes are high. We have achieved what we have by placing the greater good and a focus on recovery above all else.

As gains have been made, the forces that would pull us apart continue to grow. They include:

- **Cashing out** – People using the movement for personal gain.
- **Cooptation** – Early success increases the risk of recovery capitalist or outside entities to re-define core concepts to redirect our energy to achieve their own goal at the expense of the primary goals of the recovery movement.
- **Loss of lane** – Groups redefine their objectives for funding or other reasons, resulting in the loss of critical focus centered on common goals resulting in diminished focus on recovery for all.

The hope is to successfully sustain our movement. Achieving that would include:

- A robust **investment in long-term recovery** as the focus of our care systems for persons with severe SUDs.
- A broad focus on **developing recovery community capital** that supports recovery across all the communities that make up this nation.
- **Authentic inclusion of persons in recovery** in system design, service provision and evaluation of treatment and recovery-oriented services.
- A robust **focus on ethics** within our movement and across all of the institutional structures related to our field.

It is time to build a new, and that would start with what would be considered a fearless inventory of the good, the bad and the ugly. One of the ugliest facets of which is that we are fostering a system of dependency in the name of recovery. A system benefits a few at the expense of the many. We owe the next generation much more than an industry of self-interest at the expense of our own communities.

We do not want harm under the guise of help to be the legacy we leave the next generation.

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