NATIONAL SAFETY COUNCIL

Position/Policy Statement

Substance Use Disorder Treatment and Recovery

The National Safety Council initially passed policy position #118 (Opioid Addiction Treatment Guidelines) in November 2014. Since that time, the treatment field has expanded and grown at a rapid rate, with learnings and new evidence that requires an updated and more in-depth policy position. Additionally, it is necessary to explicitly support recovery efforts and programs. This policy replaces policy #118 with expanded and new evidence-based recommendations on treatment and recovery.

Policy/Position

The National Safety Council (NSC) supports the use of evidence-based treatment modalities for the treatment of and recovery from substance and opioid use disorders. NSC believes that successful treatment and recovery for substance use disorders requires the following:

- Addressing barriers to cost effective programs and medications that provide treatment, and;
- Increasing treatment and recovery support and management, through collaboration from states, employers, medical professionals, insurers, the community and other partners

The below recommendations detail out changes needed and steps for these two overarching actions.

Background

All substance use disorder (SUD) treatment options should be accessible and affordable. There are a variety of barriers to accessing treatment, including stigma, inability to pay or insurance coverage that is unaffordable or subject to burdensome administrative hurdles, and lack of geographical access to treatment. This can limit treatment options and result in a treatment path that is not the most effective option for the patient. Decisions about treatment modalities should be individualized and made jointly by patients and their medical staff and should not be limited by prohibitive workplace policies or limited healthcare coverage, employer or otherwise.

Addressing these barriers is critical and requires a multi-faceted approach. Both federal and state governments have a critical role to play in increasing access to treatment and recovery services.

Actions for policymakers to increase treatment access and quality include:

1. Improving insurance coverage and requiring insurers to provide coverage for the treatment of substance use disorders, in accordance with nationally recognized

guideline evidence-based guidelines and recommendations from professional medical societies
2. Increasing treatment capacity and expanding the treatment workforce
3. Increasing and standardizing telehealth services, and ensuring availability and accessibility of telehealth treatment services (see NSC Policy Position #164 on Mental Health Prevention and Treatment for more details)
4. Funding and use of Certified Community Behavioral Health Clinics (CCBHCs) and other similar centers
5. Supporting community-based programs – such as supportive housing services, job training and other wrap-around services – that assist and support individuals in treatment
6. Reducing stigma, including stigma specific to using medications for treating substance use disorders and utilizing community-based programs
7. Increasing treatment access in rural and underserved areas
8. Ensuring availability of culturally-responsive and population-specific treatment and support for women, people of color, youth, veterans, people who are incarcerated or in justice-involved programs, and other populations with specific treatment needs
9. Providing guidance to employers on increasing access to substance use treatment services and support for employees undergoing treatment. (Employers should reference guidelines released by the Equal Employment Opportunity Commission (EEOC) in August 2020 for guidance on medications for addiction treatment and the workplace.[1])
10. Ensuring mental health parity (see NSC Policy Position #136 on Mental Health Parity for details)

Increasing support for recovery includes:

1. Funding for expanding recovery support services, including but not limited to job training programs, recovery centers and communities, supportive housing, peer support programs, recovery coaching programs, and other programs supporting people living in or seeking recovery
2. Supporting research that aims to define evidence-based practices for supporting recovery
3. Establishing clear policies to support employers who hire individuals in recovery and providing incentives (such as tax credits and grants) for establishing recovery friendly workplaces

Substance Use Disorder Treatment

SUDs are complex, with biological, psychological and social causes and factors that can complicate treatment. However, SUD is a treatable medical condition, and recovery is possible with the right supports and treatment. Though more than 10% of Americans are currently in recovery,[2] this is not an easy path for many, and should be easier and on par with treatment for other medical conditions. It should be noted that many people with SUDs can't, won't, or don't find it necessary. Treatment may include medications, behavioral health counseling and other services to help patients reduce or stop alcohol and other drug use, and may address related physical or mental health problems. For most people recovering from an alcohol or opioid use

[1] https://www.eeoc.gov/newsroom/eeoc-releases-technical-assistance-documents-opioid-addiction-and-employment

[2] Kelly, J. F., Bergman, B., Hoeppner, B. B., Vilsaint, C., & White, W. L. (2017). Prevalence and pathways of recovery from drug and alcohol problems in the United States population: Implications for practice, research, and policy. *Drug and Alcohol Dependence,181*, 162-169.

disorder, medications in combination with behavioral health treatment has been shown to be most effective.[3]

Medications for addiction treatment (MAT) refer to drugs that help treat alcohol or opioid use disorder (OUD, a substance-specific subset of SUD). Three medications currently qualify as medications used to treat OUD (MOUD): methadone, buprenorphine and naltrexone.[4] Research shows that MAT significantly increases adherence to treatment and reduces opioid misuse compared with nondrug approaches, by calming cravings, reducing opioid use and helping people stabilize and lead normal lives. People who use MAT are more likely to make and maintain healthy social, psychological and lifestyle changes. Each patient will be on MAT for a different length of time determined by the doctor and the patient.[5]

People receiving a combination of therapies have better outcomes, and behavioral health treatment is recommended in conjunction with all medication therapies for SUDs. While there are many types of behavioral health therapies, they aim to:[6]

- Modify underlying behaviors that may have led to substance misuse
- Encourage patients to adhere to their prescribed medications
- Treat other existing psychiatric or psychological disorders
- Participate in counseling as needed to rebuild healthy relationships, draw healthy boundaries with unhealthy relationships, and build new support mechanisms

Recovery

Recovery begins when a person regains control over their opioid or substance use disorder and starts to live a healthy, productive life.[7] Recovery is a personal journey that can vary greatly from person to person. For this reason, there are many different guiding principles when supporting recovery. Recovering from an OUD or SUD may include making significant lifestyle changes that may be difficult to maintain – for example, coping with stress and distress without alcohol or other substances. Relapse is natural a part of recovery.

There are four major dimensions to recovery[8]:

- Health – overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way;
- Home – a stable and safe place to live;
- Purpose – meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and
- Community – relationships and social networks that provide support, friendship, love and hope.

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[3] https://www.samhsa.gov/medication-assisted-treatment/treatment#medications-used-in-mat
[4] https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/how-do-medications-to-treat-opioid-addiction-work
[5] https://www.nsc.org/Portals/0/Documents/RxDrugOverdoseDocuments/RxKit/2019/Basics/Treatment-and-Recovery-in-the-Workplace.pdf
[6] Substance Abuse and Mental Health Services Administration. (2019, January 14). Behavioral Health Treatments and Services. Retrieved February, 2019, from https://www.samhsa.gov/find-help/treatment
[7] https://www.naadac.org/recovery-definitions
[8] Ibid

Former Surgeon General Dr. Jerome Adams stated:

> Recovery from substance use disorders has had several definitions. Although specific elements of these definitions differ, all agree that recovery goes beyond the remission of symptoms to include a positive change in the whole person. In this regard, 'abstinence,' though often necessary, is not always sufficient to define recovery. There are many paths to recovery. People will choose their pathway based on their cultural values, their psychological and behavioral needs, and the nature of their SUD.[9]

This means that supporting recovery requires supporting a variety of methods and not adopting a one-size-fits-all approach, including a move away from unnecessarily punitive policies and programs, such as zero-tolerance programs.

Recommendations

Treatment

1. Improving insurance coverage and requiring insurers to provide coverage for the treatment of substance use disorders in accordance with nationally recognized guideline evidence-based guidelines and recommendations from professional medical societies

This includes full coverage for treatment medications and therapies, and requiring insurers to provide coverage for the treatment of SUD in accordance with nationally recognized guidelines (the ASAM National Practice Guideline for the Treatment of Opioid Use Disorder, for example) for placement, medical necessity, and utilization management determinations. This includes removing step therapy, prior authorization and other restrictive utilization management policies that deny and delay care. Additionally, a focus must be on ensuring high quality care by increasing adoption of payment models that encourage collaborative, integrated care and providing full coverage for treatment medications and therapies. In detail, insurers should:

- Provide complete coverage of all evidence-based treatment options. Different treatments work differently for different people, which means that all evidence-based treatment options should be equally and easily accessible and affordable. Plans should cover comprehensive treatment options for people with substance use disorder that include coverage for:
    - Confidential substance use screening
    - Brief intervention and referral to treatment
    - Outpatient and inpatient treatment
    - Medications for addiction treatment
    - Counseling and medical services
    - Follow-up services during treatment and recovery

  Additionally, plans should not limit duration of coverage. Substance use disorders are, by definition, a chronic illness, like diabetes.[10] Treatment may take place over weeks, months or years. Interruptions to treatment (for any reason) are linked with increased risk for relapse and overdose.[11] This is a complex issue in that, even if there is no stated limit in a plan related to number of visits or days, it is a back-and-forth between the

[9] https://addiction.surgeongeneral.gov/sites/default/files/OC_SpotlightOnOpioids.pdf
[10] https://www.drugabuse.gov/publications/media-guide/science-drug-use-addiction-basics
[11] https://www.who.int/news-room/fact-sheets/detail/opioid-overdose

treatment provider and the insurance company, often resulting in sub-optimal results for the patient. Plans also should not employ utilization management protocols such as prior authorization or step therapy that interfere with the beginning or continuation of treatment. Employers are encouraged to ensure that SUD treatment contains no prior authorization requirements.

- Ensure parity. NSC supports mental health parity so that coverage, payment, and treatment for mental health conditions and substance use disorders are no more restrictive than or equal to that of other chronic and acute health conditions (learn more in the NSC Policy Position #136 on Mental Health Parity). In particular, NSC supports the following recommendations for employers from President Obama's Mental Health and Substance Use Disorder Parity Task Force final report from October 2016:
    - Supporting consumers and providing parity education and awareness
    - Clarifying parity requirements and improving implementation
    - Improving and enhancing compliance and monitoring

  The 116th Congress recently amended the Mental Health Parity and Addiction Equity Act (MHPAEA) by requiring employer-sponsored group health plans to perform comparative analyses demonstrating their compliance with the law's existing non-quantitative treatment limitation specifications. Self-insured employers should ensure that their plan administrators are proactively performing these analyses and have them available to submit to regulators upon request. Employers should advise their plan administrators to refer to Section F of The United States Department of Labor's Self-Compliance Tool for MHPAEA for guidance on how to perform the analyses.
- Ensure Medicaid covers all treatment options equally (see NSC Policy Position #162 on Medicaid Support for Mental Health and Substance Use Disorder) and reimburses appropriately increase provider acceptance. In particular, NSC supports efforts to expand Medicaid and minimize barriers to care. This would include covering telehealth, removing prior authorization requirements, discontinuing arbitrary coverage limits, and eliminating work requirements.
- Reduce barriers, including those imposed by federal regulation, and increase implementation of contingency management (CM) techniques in treating SUD, a treatment that provides reinforcers (e.g., vouchers, prizes) for a targeted behavior such as abstinence from substance use.[12] CM is one of the most effective behavioral interventions for substance use,[13,14] allowing patients to take fuller advantage of other clinical treatment components. Barriers exist for implementation, including that it can be unlawful to provide contingency management to patients who are enrolled in health plans or programs that are funded by federal or state dollars,[15] as well as barriers related to negative philosophical views.[16]
- Assess and, if appropriate, implement innovative models for payment reform to move beyond patient stabilization to a biopsychosocial sustained model of recovery

[12] https://psycnet.apa.org/manuscript/2019-35851-001.pdf
[13] https://pubmed.ncbi.nlm.nih.gov/17034434/
[14] https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-therapies/contingency-management-interventions-motivational-incentives
[15] https://www.healthaffairs.org/do/10.1377/hblog20200305.965186/full/
[16] https://psycnet.apa.org/manuscript/2017-27173-001.pdf

management, such as the Addiction Recovery Medical Home Alternative Payment Model[17]

2. Increase treatment capacity and expand the treatment workforce by:[18]
    - Encourage adoption of payment models that ensure collaborative, integrated care and provide full coverage for treatment medications and therapies, including increasing the Medicaid and other public aid reimbursement rate. An example is the use of the Collaborative Care model, which integrates behavioral health care, including SUD care, within the primary care setting and has over 90 studies demonstrating its efficacy and emerging evidence supporting its efficacy for treatment of SUD.
3. Increasing and standardizing telehealth services, and ensuring availability and accessibility of telehealth treatment services by:[19]
    - Implementing payment parity
    - Researching and updating licensing requirements to make it easier to provide telehealth services, while recognizing that new policies and implementation models can result in unanticipated impacts on providers, insurers, and patients. Continued evaluation and appropriate amendments to policies and models must be prioritized.
    - Improving and standardizing coverage models, payment mechanisms and reimbursement practices for telehealth services across government (Medicaid and Medicare) and private payers
    - Removing barriers to accessing telehealth services, including:
        - Covering technology and other services needed to ensure patient access to telehealth services
        - Allowing initiation of care virtually
        - Removing utilization review practices that are not in place for in-person care or are more restrictive than utilization review for in-person care
    - Increasing telehealth capacity and removing barriers for providers of MAT and other SUD treatment interventions
    - Researching when SUD telehealth service is or is not a good stand-in for in-person care
    - Developing standards of care for providing SUD telehealth services
    - Applying the developed standards of care to all telehealth providers to ensure quality of care is maintained and individualized to the specialty to avoid an overly general one-size fits-all approach

This must be done while recognizing that not all people are able to, have access to, or will want to utilize telehealth services. This is why networks and access to technology must be factored into new policies.

4. Fund and use Certified Community Behavioral Health Clinics (CCBHCs) and other similar centers[20]

CCBHCs are nonprofit organizations or units of a local government behavioral health authority. According to the National Council on Behavioral Health, CCBHCs are designed to provide a comprehensive range of mental health and SUD services to vulnerable individuals. In return, CCBHCs receive an enhanced Medicaid reimbursement rate based on their anticipated costs of

[17] https://2bae3941-47b8-498f-b712-7ba9cc56feb7.filesusr.com/ugd/4b8a91_4d985013b4f5438dace884cc6a961dc8.pdf
[18] Adapted from the NSC Policy Position #164 on Mental Health Prevention and Treatment and the NSC National Plan to Address Opioid Misuse
[19] Adapted from the NSC Policy Position #164 on Mental Health Prevention and Treatment
[20] Ibid

expanding services to meet the needs of these people. They must directly provide (or contract with partner organizations to provide) nine types of services, with an emphasis on the provision of 24-hour crisis care, evidence-based practices, care coordination with local primary care and hospital partners, and integration with physical health care.[21]

The benefits of CCBHCs in addressing behavioral health needs are clear. Some highlights include:

- An expanded and enhanced workforce that increases CCBHC capacity to provide care and increase the quality of the care
- Expanded services for people with SUDs
- Enhanced patient reach and engagement
- Service provision outside the traditional clinic

CCBHCs are reliant on annual federal funding through the Substance Abuse and Mental Health Services Administration (SAMHSA). NSC supports measures to maintain or increase current funding, and to eventually secure long-term funding to stabilize the program.

5. Support community-based programs that provide wrap-around services – such as housing services, job training, financial support, etc. – that assist and support individuals in treatment

Research has demonstrated that providing wrap-around services enhances treatment retention and improves treatment outcomes.[22] People in workplace-mandated treatment have better or similar outcomes on a variety of metrics, including employment stability at 1 and 5 years after treatment.[23] Recognizing the role that many systems (housing support, job training, financial services, childcare, etc.) play in supporting people in treatment and recovery, NSC supports efforts to align and integrate systems and services and encourage cooperation between systems, services and sectors. Additionally, NSC recognizes that the funding structure for many of these community-based programs varies. In cases where federal or state funding can be allocated to support such programs, NSC encourages funders to consider the important role these programs play in helping people stay in treatment and find recovery.

6. Reduce stigma against treatment, including stigma specific to using medications for addiction treatment

Stigma is already associated with a variety of negative health outcomes, as it is a barrier to health seeking behaviors, engaging in care, and adherence to treatment.[24] Bias and stigma have existed against the use of MAT or MOUD for years, in part because some of these medications are opioids themselves, used in a similar way to a nicotine patch (used to stabilize and eventually wean the patient off opioids in a controlled manner).[25]

[21] https://www.thenationalcouncil.org/wp-content/uploads/2017/11/What-is-a-CCBHC-11.7.17.pdf?daf=375ateTbd56
[22] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4711315/
[23] https://ps.psychiatryonline.org/doi/full/10.1176/ps.2009.60.5.646
[24] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6376797/
[25] http://pcssnow.org/wp-content/uploads/2015/03/Stigma-in-Methadone-and-Buprenorphine-Maintenance-Treatment-ASAM-Module.pdf

There is a widespread belief that use of MAT is essentially substituting one drug for another,[26,27,28] which, to some, contradicts the more traditional, abstinence-based definitions of "successful" treatment and recovery. In this case, MAT can have negative moral connotations,[29] and stigma exists among healthcare professionals, family members of individuals in treatment and even recovery communities. These varying stigmatizing beliefs can also prevent people with SUD from using MAT due to their own negative beliefs.

However, MAT does not mean that patients are trading one addiction or substance for another, nor does it prolong addiction.[30] Combatting this stigma must focus on several audiences, including healthcare personnel,[31] employers,[32] patients in treatment and recovery communities, and the general population. NSC supports efforts, programs and funding aimed at reducing stigma against treatment for substance use disorders, particularly in regards to MAT.

7. Increase treatment access in rural and underserved areas

The Centers for Disease Control and Prevention (CDC) found that drug-related deaths are 45% higher in health professional shortage areas (HSPA), where there is a lack of access to qualified clinicians who can provide needed treatments and services, and that rural states are more likely to have higher rates of overdose deaths.[33] The Pew Charitable Trusts noted that overdose deaths increased 325% in rural counties between 1999 and 2015, at which point they surpassed the death rate in urban areas.[34] In comparison with urban counterparts, rural communities have fewer facilities to choose from, face more limited services, and greater physical distances to care for patients seeking treatment.[35]

Increasing access to and availability of telehealth, increasing presence and funding of CCBHCs and other methods can help address the limited availability of SUD treatment in rural and other underserved areas. NSC supports efforts, programs and funding aimed at addressing these shortages. Examples of this include the suite of programs that the U.S. Department of Health And Human Services (HHS) Health Resources and Services Administration (HRSA) has funded, including workforce loan repayment programs and programs aimed at increased the number of addiction specialists at facilities in HSPAs, and a variety of state programs aimed at increasing rural access to treatment that can be explored here.

8. Ensure availability of culturally-responsive and population-specific treatment and support for populations with elevated risk and specific treatment needs

According to SAMHSA, the development of culturally-responsive clinical skills is vital to the effectiveness of behavioral health service. SAMHSA states that cultural competence "refers to the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. Cultural competence is a dynamic, ongoing developmental process that requires a

[26] https://www.socialworktoday.com/archive/JA18p10.shtml
[27] https://www.careinnovations.org/wp-content/uploads/Stigma-and-Stigma-Injury-compressed.pdf
[28] https://blog.cleanslatecenters.com/stigma-against-addiction-medication-fading-ringing-in-hopeful-signs-for-opioid-epidemic-in-2019
[29] https://pcssnow.org/resource/myths-and-misconceptions-medication-assisted-treatment-for-opioid-addiction/
[30] Ibid
[31] https://pubmed.ncbi.nlm.nih.gov/31125801/
[32] https://www.shatterproof.org/sites/default/files/2020-07/A-Movement-to-End-Addiction-Stigma.pdf
[33] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4455515/
[34] https://www.pewtrusts.org/-/media/assets/2019/02/opioiduseruralcommunities_final.pdf
[35] Ibid

long-term commitment and is achieved over time."[36] Culturally responsive skills can improve client engagement in services, therapeutic relationships between clients and providers, and treatment retention and outcomes.[37] Culturally competent treatment has also been associated with better outcomes in racial and ethnic minority adolescents.[38]

Cultural competence is also an essential ingredient in decreasing disparities in behavioral health, and in particular, can address population-specific risk factors. Both individual and social or systemic risk factors (resulting from issues present in the overall system, e.g. economic vulnerability) play a role in increasing risk for developing a substance use disorder. Substance misuse and development of substance use disorders are also shaped, to great extent, by the social, economic and physical environments in which people live.[39]

Factors that increase risk include:

- Physical or biological (e.g. family history of mental illness, alcohol or drug use, other health conditions, gender)
- Psychological (e.g. stress, trauma) or social (e.g. living in poverty, unstable housing, unemployment, racial or ethnic background)

Protective factors that decrease the risk[40] can include:

- Physical / biological (e.g. healthy diet, exercise, lack of other health conditions, no substance use)
- Psychological (e.g. reliable support from family, good coping skills) or social (good relationships with family and friends, economic and financial security)

NSC supports efforts, programs and funding that focus on increasing availability of culturally-responsive and population-specific treatment and support for women, people of color, youth, veterans, people who are incarcerated or in other justice-involved settings (including the provision of MAT in correctional facilities), and other populations with specific treatment needs. Additionally, NSC supports research that focuses on understanding how to increase quality of care and that addresses specific needs based on risk factors listed above.

9. Providing guidance to employers on increasing access to treatment services and support for employees in treatment[41]

The EEOC issued two guidance documents[42] addressing the opioid epidemic and its impact on the workplace in August 2020, providing clarity on opioid use disorder and its relation to the Americans with Disabilities Act (ADA). This guidance is critically important for workplaces as they support employees with an opioid use disorder. NSC supports efforts that ensure employers are aware of and abide by the EEOC guidance stating that individuals on MAT are protected from disability discrimination.

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[36] https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4849.pdf

[37] https://www.researchgate.net/publication/311679268_Cultural_Competence_in_the_Treatment_of_Addictions_Theory_Practice_and_Evidence

[38] http://mdft.org/mdft/media/files/Publications/Steinka-Fry-et-al-(2017)-Culturally-sensitive-substance-use-treatment-for-racial-ethnic-minority-youth.pdf

[39] https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf?sequence=1

[40] https://www.americanmentalwellness.org/prevention/risk-and-protective-factors/

[41] Adapted from NSC Policy Position #169 on Opioids and Employers

[42] https://www.eeoc.gov/newsroom/eeoc-releases-technical-assistance-documents-opioid-addiction-and-employment

Addressing opioid use in the workplace and increasing access to treatment services and support for employees in treatment is a complex undertaking. NSC recommends the following actions to support employees as they return to work during and following treatment:

1. Expanding Employee Assistance Programs (EAP) and their role in providing barrier-free preventive services, screening and early identification services, short-term counseling, referral to specialty treatment and other behavioral health interventions related to opioid use and misuse
2. Ensuring insurance coverage of evidence-based treatment for opioid use disorder, including all three FDA-approved medications use to treat OUD, and addressing other disparities and gaps in healthcare benefits
3. Supporting a stigma-free, recovery-friendly workplace culture

More information about detailed actions employers can take – and the government can take to help support them – in NSC Policy Position #169 on Opioids and Employers.

10. Ensuring mental health parity[43]
    - In particular, NSC supports the following recommendations for employers from President Obama's Mental Health and Substance Use Disorder Parity Task Force final report from October 2016:
        - Supporting consumers and providing parity education and awareness
        - Clarifying parity requirements and improving implementation
        - Improving and enhancing compliance and monitoring

      Additionally, the 116th Congress recently amended the Mental Health Parity and Addiction Equity Act (MHPAEA) by requiring employer-sponsored group health plans to perform comparative analyses demonstrating their compliance with the law's existing non-quantitative treatment limitation specifications. Self-insured employers should ensure that their plan administrators are proactively performing these analyses and have them available to submit to regulators upon request. Employers should advise their plan administrators to refer to Section F of The United States Department of Labor's Self-Compliance Tool for MHPAEA for guidance on how to perform the analyses.

Recovery

1. Funding expanded recovery support services, including but not limited to job training programs, recovery centers and communities, supportive housing, peer support programs, recovery coaching programs, and other programs for people who are in or seeking recovery

One person's recovery may differ dramatically from another's recovery, and a variety of recovery support services are necessary. For example, programs that focus on building a recovery community, including supportive recovery housing, peer support or coaching programs, programs in correctional facilities, etc., are critical. Additionally, ensuring recovery support programs with different modalities are widely available is essential so that people in recovery have access to the support type that works best for them. Lastly, skills-based programs, such as job training and financial education, are critical for a successful recovery.

Research has demonstrated that providing wraparound services enhances treatment retention, improves outcomes and helps keep people in recovery.[44] Recognizing the simultaneous role that many support systems (i.e. housing, job training, financial services, childcare, etc.) play for

[43] Adapted from the NSC Policy Position #136 on Mental Health Parity
[44] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4711315/

people in treatment and recovery, NSC supports efforts to align, integrate and encourage cooperation among different systems, services and sectors.

2. Supporting research that aims to define evidence-based practices for supporting recovery

Abstinence is not the sole, and can be highly misleading, barometer of recovery success, and the definition of recovery is highly personal and unique to the individual. Recovery also involves improvements in functioning, such as holding gainful employment, proper management of chronic health conditions, and repairing and maintaining supportive relationships. Common components of recovery include family support, social mobility, employment, mental health, sense of purpose and community.[45] NSC supports funding for, research on and development of evidence-based efforts and programs that support recovery, focusing on recovery communities and skills-based and recovery programs.

3. Establishing clear policies to support employers who hire individuals in recovery and providing incentives for establishing recovery friendly workplaces

One component of a successful recovery is gainful employment, and by embracing people with SUDs, employers play an important role in helping those in recovery. A supportive workplace environment can greatly improve employees' chances of recovery, create job satisfaction and workplace loyalty by preventing feelings of stigma and isolation and the possibility of a relapse. People in recovery often have a high degree of self-awareness, resilience, compassion, dedication and understanding. These valuable skills and behaviors can have positive impact for workplace teams, company and culture. Relapse is an opportunity to support treatment, and punitive measures will almost certainly lead to adverse consequences.

However, employers may require incentives such as tax credits, as well as resources and guidance. NSC supports additional funding and efforts for:

- NIOSH workplace supported recovery programs (WSRP), which create a supportive, recovery-friendly workplace for people in recovery, using a variety of tactics to prevent exposure to negative workplace factors.
- Training and re-entry programs that focus on –
    - Helping people with a substance use disorder re-enter the workforce. The SAMHSA Treatment, Recovery, and Workforce Support Grant is an excellent example of providing funding for these programs.
    - Ensuring the workplace is prepared by training supervisors and managers, and creating supportive policies. The Opioids & Substance Use: Workplace Prevention & Response Worker Training Program from the National Institute of Environmental Health Sciences (NIEHS) at the National Institutes of Health (NIH) is one such example.
    - Providing funding and incentives to workplaces who become recovery-friendly and/or focus on hiring workers in treatment and recovery. A state level example of this is New Hampshire, where the state allocated a one-time, $1M appropriation to administer grants to nonprofit organizations for programming through the Recovery Friendly Workplace (RFW) Initiative. Funds are also available for nonprofit organizations to implement programming that will:

[45] https://www.recoverycapital.io/

- Educate employers in evidence-based practices that demonstrably reduce substance misuse in the workplace;
- Create work environments that enable persons in addiction and mental health recovery to re-enter the workforce as productive members of society;
- Train employees, including specialized training for human resources personnel;
- Raise public awareness and provide information that supports health and safety for employees; and
- Promote active community engagement to reduce the negative impact of unaddressed substance use disorders.

Conclusion

Increasing access to evidence-based treatment services and supporting people with a substance use disorder and living in recovery is a top priority as the United States addresses both the drug overdose crisis and impacts from the COVID-19 pandemic, which may impact substance use for years to come. Policymakers should prioritize both reducing barriers to treatment, ensuring quality treatment, and supporting individuals living in recovery.

This position statement reflects the opinions of the National Safety Council but not necessarily those of each member organization.

Adopted by the National Safety Council, September 2021
Supersedes Opioid Addiction Treatment Guidelines, Policy 118