Recovery Community Centers

History, Effectiveness, Best Practices & Staff Competencies

DACUM SME Facilitators
Tony Vezina, BSW, CADC-I, CRM-II, Debi Elliott, PhD & Jerrod Murray, CADC-I, CRM-II

DACUM SME Workgroup
Debra Buffalo-Boy, CADC-II, CRM-II
Janie Gullickson, MPA:HA, PSS
Julia Mines, MS, MSW, CADC-III, QMHPC
Cody Roberts, CADC-II, CRM-II, QMHA-R
Amanda Esquivel, BFA, CRM-II
Stephanie Cameron, CADC-II, CRM-II
Brittany Wilson, CRM, PWS
Eric Martin, MA, CADC-III, CRM-II, CPS

Editor
Sharmalee R. Nadarajah, BS, PWS, CRM

Psychometrician
Cynthia Beckworth, EdS

A DACUM research-based, validated Best Practice & Staff Competency Guide

Oregon Health Authority Office of Recovery and Resilience
The Alcohol and Drug Policy Commission
MetroPlus Association of Addiction Peer Professionals

Recovery Community Centers: History, Effectiveness, Best Practices & Staff Competencies

DACUM SME Facilitators

Tony Vezina, BSW, CADC-I, CRM-II, Debi Elliott, PhD & Jerrod Murray, CADC-I, CRM-II

DACUM SME Workgroup

Debra Buffalo-Boy, CADC-II, CRM-II
Janie Gullickson, MPA:HA, PSS
Julia Mines, MS, MSW, CADC-III, QMHPC
Cody Roberts, CADC-II, CRM-II, QMHA-R
Amanda Esquivel, BFA, CRM-II
Stephanie Cameron, CADC-II, CRM-II
Brittany Wilson, CRM, PWS, PSS
Eric Martin, MA, CADC-III, CRM-II, CPS

Psychometrician

Cynthia Beckworth, Ed.S.

Editor

Sharmalee R. Nadarajah, BS, PWS, CRM

A DACUM research-based, validated Best Practice & Staff Competency Guide

Nationwide Co-Authors: SME Facilitators, Subject Matter Experts, and Survey Participants

Jacob Abbott
Rebecca Alldridge
Candice Altman
John Armas
Jolena Bakanoff CRM
Chrissy Barnard, CRM II, CADC I
Cynthia Beckworth, Ed.S.
Angie Bertrand, ED, Peer 180 RCC
Kaitlyn Brown
Gina Brunelle
Meagan Buchanan
Deborah Buffalo-Boy, CADC-II, CRM-II
Will Burchard, MS, PWS
Stephanie Cameron, CADC-II, CRM-II
Stacy Charpentier, RCPF, CPRS
Austin Cole
Haile Conklin
Joshua Covington, CRM
Kelly Crowder CRM-ll, PWS
Alisha Dicken, TRADPSS
Johanna M. Dolan, MSIOP, BCC, SIC, RCP-F, RPS
Debi Elliot, PhD.
Brenda Essary
Leonel Estel
Amanda Esquivel, BFA, CRM-II
Dakota Ewing, CRM
Lyric Farmer
Baubee Federle
Benjamin Fowler, CRM, PWS
Rachel Fowler, MS, NCPRSS
Jillian Fuller CADC-I, QMHA R,
Kelley Gerini, RPS
Mina Gilson, BFA, CADC-I, CRM-II
Christopher Goldman, BA, CRM-II
Paul Gonzales
Antoinette Gonzalez, CRPS-A, CEI
Andrea Gross, CADC I, CRM II
Justin Gulbranson
Janie Gullickson, MPA:HA, PSS
Destiny Hammons, CRM
Stephanie Hector
Mitchell Henderson
Julia Mines, MS, MSW, CADC-III, QMHPC
Melissa Hereford
Camille Ireland-Esquivel, BS, CADC-I, CRM-II
Tyler Jones
Dixon Jones
Jared Karter
Michelle Kavouras
Darrell Keim
Caitlin Koucky, MNM
Brandy Kueffner, Peer Recovery Coach
Jennifer Leech
Devin Machado
Eric Martin, MA, CADC-III, CRM-II
Gwynne McCay
Samantha Mejia
Mico Morran
Jerrod Murray, CADC-I, CRM-II
Tara Nall
Sharmalee R. Nadarajah, BS, PWS, CRM
Jonah Oxley, CRM-II
Crystal Pearsall CRM II
Jason Ricketson
Cody Roberts, CADC-II, CRM-II, QMHA-R
Scott Robinson CRM, PSS, YSS
David Rudder, CRM, PSS, CHW
Robert Sanders, CRM-II, CADC-I, QMHA-R
John Sherwood, MA, CADC, CRC
Shanna Smith
Kurt Smith
Caleb Sprenger, CRM
Abbi Turner, PSS, CRM
Crystal Ulibarri, CRM
Raymond Underkofler, CRM
Virginia Valenzuela, CRPS-A
Tony Vezina, BSW, CADC-I, CRM-II
Devan Walbert
Goldie Ward CRM II, CADC-R
Gabrielle Ward, CRMll, CADC-l, QMHA-R
Alissa Wilson
Nickolas Wilson, CPSS-T
Brittany Wilson, CRM, PWS, PSS
Scot

Introduction

Very little has been authored on the subject of Community Recovery Center Best Practices and Staff Competencies. This best practice and role delineation analysis was produced through a series of investigative protocols, including: a review of the literature, DACUM SME workgroup, quantitative validation survey, psychometric analysis, and final DACUM SME editing.

This best practice analysis is specifically designed for training and evaluation purposes. Best practices are described in checkboxes for classroom participant self-assessment.

Classroom Directions

This text is designed for in-class training.

1. Review and discuss a best practice and associated staff competencies.
2. Ask each participant to complete the associated self-assessment check box. The self-assessment check box can also be used as an "agency & staff self-assessment" check box.
3. In groups, have participants discuss their strengths and areas for improvement based on their self-assessment.
4. Facilitate a class discussion on the insights individuals gained through their self-assessment and group discussions.
5. Move forward to the next best practice and repeat the process.

Methodology

1. **Stage One: Grey Literature Review**. A search of research journal articles, documents, guides, curricula, periodicals, organizational publications, and text were performed to identify resources associated with the operation of Behavioral Health Recovery-Oriented Community Drop-in Centers (Recovery Community Centers, Community Recovery Centers, Addiction Recovery Support Centers, Sober Clubs, Clubhouses, Living Rooms, Alano/24-hour Clubs, Sober Bars, Recovery Cafes, RCO Drop-in Centers and the Social Model of Recovery). 137 references were identified as relevant research or practice-based evidence regarding the operation of recovery-oriented drop-in community centers. This literature review aims to identify the most common and effective practices observed in the operation of recovery-oriented venues, specifically applicable to Recovery Community Centers.
2. **Stage Two: DACUM Subject Matter Experts (SMEs).** The SMEs group was comprised of experienced peers working in Recovery Community Centers. The DACUM SME workgroup analyzed the grey literature review, summarized best practices and edited language in preparation for a nationwide survey of Recovery Community Center staff.
3. **Stage Three: Quantitative Likert Validation Surveys.** The SMEs refined the essential Best Practices based upon the literature review. The Best Practices were sent in a survey format to 1,480 peers nationwide who work for or are affiliated with Recovery Community Centers. 77 survey participants rated the Best Practices for "criticality/importance" and "clarity/accuracy" on a Likert scale. Additionally, participants were also given the opportunity to write-in feedback.
4. **Stage Four: Psychometric Assessment**. Survey results were analyzed using Lawshe's Content Validity Ratio, Criticality scales and Clarity scales, which informed SMEs of Best Practice statements to be edited or removed.
5. **Stage Five:** DACUM Curriculum. Final edits to the Recovery Community Centers: Bes

$$\mathrm{CVR} = \frac{n_e - (\frac{N}{2})}{\frac{N}{2}}$$

Practices were produced by the SMEs, and curriculum assessment grids were produced for training and evaluation purposes.

This Best Practice and Staff Competency Analysis was funded through The MetroPlus Association of Addiction Peer Professionals through a grant from the Oregon Health Authority, Behavioral Health Division.

Recommended Citation:

Vezina, T., Elliott, D., & Murray, J. (2026). Community recovery centers: History, effectiveness, best practices & staff competencies. MetroPlus Association of Addiction Peer Professionals.

Table of Contents

Recovery Community Centers: History, Effectiveness, Best Practices & Staff Competencies

The History of Recovery Community Centers

Today's Recovery Community Centers differ from traditional clinical treatment centers, or traditional recovery clubhouses.

Recovery Community Centers have a specialized focus on socialization or the "Social Model of Recovery", they host mutual aid groups (12-step, Wellbriety, SMART, Refuge Recovery, etc.), and typically offer professional peer delivered services from trained-certified peers.

Historically, there have been a variety of names for community styled addiction and mental health recovery centers:

- 24-hour Clubs
- Alano Clubs
- Sober clubs
- Recovery Community Organizations
- Recovery Cafes
- Recovery Clubs
- Living Rooms
- Clubhouses
- Community Recovery Centers

Recovery Community Centers also differ from mental health oriented drop-in centers, often referred to as Living Rooms or Clubhouses, or other types of drop-in centers for houseless individuals. Recovery Community Centers are typically more focused on recovery from substance use disorders, compared to their mental health counterparts (Clubhouse International, NAMI centers, Living Rooms, etc.).

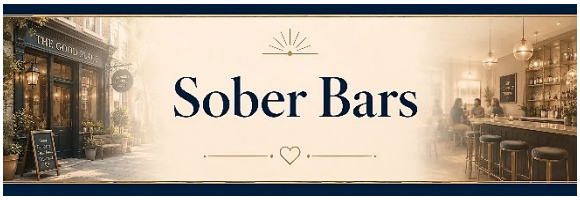
William White, an addiction recovery historian, details roughly 20 recovery groups, referred to as "clubs", that were formed during the 19th century. These clubs met regularly for mutual aid and support, and are widely recognized as being the forebears of modern recovery groups.

Some of the "clubs" in operation during this time include:

- Ollapod Club
- Royal Reform Club
- Blue Ribbon Reform Club

- Red Ribbon Reform Club
- Jacoby Club

However, the term “club” refers to a group of organized members, rather than to a brick-and-mortar location used for socialization. For example, the Ollapod Club met at the New York Inebriate Asylum, and the Jacoby Club met at a local detoxification center.



During the late 19th century, the “Temperance Movement” began, in which political leaders and individual citizens advocated for reductions in alcohol consumption, then for complete abstinence. From these social reform efforts, the next iteration of recovery clubs emerged: “Temperance Bars”. Temperance Bars were alcohol-free, safe social spaces for all. In recent years, Temperance Bars have made a comeback as modern sober bars or recovery clubs, whose primary function is to provide sober spaces for entertainment and positive social interaction.

Fitzpatrick’s Temperance Bar, est. 1899

One of America’s first recovery centers was founded in 1940 by Bert T. and Horace C., who rented a small building at 334 1/2 West 24th Street in Manhattan. “The Clubhouse” not only hosted 12-step meetings, but also served as a drop-in center where members could socialize, eat, drink coffee, etc.

1940 New York Clubhouse in Manhattan

The Clubhouse, est. 1940, 334 1/2 West 24th Street in Manhattan

Alcoholics Anonymous (A.A.) Guidelines from the General Service Office (GSO) state, "Since the early days of A.A., some members have sought a place to go for coffee and conversation; a spot where they could have lunch with friends; a place where they could gather socially on weekends and holidays. Clubs developed organically to fill this need, with the first one in New York City followed by many more throughout the country".

Similarly, in a Grapevine article from 1947, Bill W., the co-founder of A.A., wrote, "There would be thousands who would testify that they might have had a harder time staying sober in their first months of A.A. without clubs and that in any case, they would always wish for the easy contacts and warm friendship which clubs afford."

However, A.A.'s early relationship with clubs was complex and fraught with tension due to challenges arising from questions of finances, management, and personal authority, as well as the risk that clubs would degenerate into mere social hangout spots without a recovery focus. In the same article Bill acknowledged, "But we have A.A.'s, rather a strong minority, too, who want no part of clubs. Not only, they assert, does the social life of a club often divert the attentions of members from the program, they claim that clubs are an actual drag on A.A. progress. They point to the danger of clubs degenerating into mere hangouts, even 'joints'; they stress the bickering's that do arise over questions of money, management, and personal authority; they are

afraid of 'incidents' that might give us unfavorable publicity. A.A.'s relationship with clubs is long and varying in detail. The idea behind clubs was to offer a place large enough for members to meet and gather after the meeting, one imbued with a '*home atmosphere*.' After starting the first, individual members quickly learned the benefits of having a club — and the liabilities as well."

Over time, club members became more knowledgeable about the potential risks, and today, the home-like environment and opportunities for socialization offered have made clubs an important part of our modern recovery ecosystem.

In 1948, the first mental health "Clubhouse" was formed after six patients discharged from Rockland State Hospital after World War II envisioned a place for individuals with mental illness to gather for mutual social support and mental health recovery. This clubhouse was called Fountain House.

Initially, the pioneering members of Fountain House had merely hoped to give individuals with mental illness a place to go after discharge from a psychiatric facility, but their vision evolved greatly over the subsequent six decades into locations where members could find vocational and housing support, as well as social support.

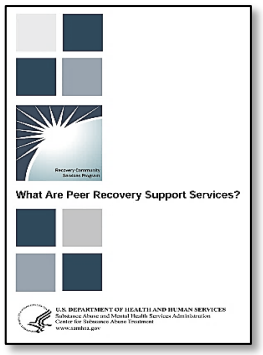
Fountain Clubhouse, est. 1948, New York City

Clubhouse International
Creating Community: Changing the World of Mental Health

Since Fountain House's conception, hundreds of Clubhouses for individuals with mental illness have emerged worldwide. Clubhouse International, a global non-profit focused on clubhouse development and support, has played an integral role in this expansion by developing best practices that they applied to an accreditation process. Clubhouse International promotes the social model of mental health recovery and, through it, has assisted thousands of individuals worldwide in finding supportive, recovery-focused environments in which they can thrive.

Clubhouse International
ACCREDITED

SAMHSA funds RCCs



In 1998, the Substance Abuse and Mental Health Services Administration (SAMHSA) funded The Recovery Community Services Program (RCSP) grants. They reported, "A number of RCSP grantees have created recovery community centers as 'places where recovery happens.' Many types of peer service activities—such as mentoring and coaching, connecting resources, support and educational groups—take place at these centers. At the core of the effort is the nurturing of a caring recovery community, with shared norms and values, which is dedicated to supporting the recovery of all who seek it. These centers 'bring recovery to Main Street' and, by making recovery visible, carry a message of hope to the larger community."

Research on the Effectiveness of Recovery Community Centers

Recovery Community Centers have existed in various forms over the last century, from early iterations of Temperance Bars, to A.A. clubs, to mental health recovery Clubhouses. However, the majority of current club-related research has focused on the effectiveness of 12-step meetings occurring in clubs, rather than the effectiveness of the clubs themselves. This is a significant research gap, since recovery centers are much more than locations for mutual aid meetings. Importantly, they are also environments aligned with the Social Model of Recovery, in which individuals can experience mutuality through peer support and vital connection with others seeking recovery.

Minneapolis Alano Club, est. 1942, 2218 1st Avenue South Minneapolis

These clubhouse social venues have long been viewed as a support system for the greater clinical model, or simply a support system for the mutual aid groups they house. Therefore, little research has been invested into their effectiveness as social venues.

Portland Alano Club est. 1947, 909 NW 24th Ave, Portland

A systematic review of U.S. Recovery Community Center (RCC) studies by Kelly and colleagues (2025) identified only seven eligible studies, and of these, none used rigorous research methods such as controls and randomization, nor did any have follow-up periods longer than 6 months.

Across those studies, greater RCC participation was generally associated with better substance-use outcomes, higher recovery capital, and better psychosocial functioning, but the review emphasized major methodological weaknesses, and the researchers concluded that the evidence base is still limited and mostly correlational.

Another study by Kelly and colleagues (2021) followed 275 new attendees at seven Northeastern Recovery Community Centers for three months. These newcomers started out with high clinical need, high financial challenges, and low quality of life. The most utilized and valued services were recovery coaching meetings, access to technology, and employment assistance. Over a period of three months, participants showed longer periods of abstinence, fewer substance-related problems, better psychological well-being, and better quality of life, although recovery assets did not improve significantly.

A significant area of complexity to note is the growing argument that the effectiveness of Recovery Community Centers should not be judged by abstinence alone. In a study by Hoeppner and colleagues (2025) based on a nationwide survey of RCC Directors, the authors found strong support for outcomes such as recovery capital, quality of life, well-being, and the development of life goals. The researchers also highlighted that centers are meant to help at the individual, interpersonal, and community levels.

McKay and colleagues' (2016) systematic review of 52 studies also found evidence supporting the Clubhouse Model for employment, reduced hospitalization, and improved quality of life, with additional observational support for social and educational outcomes. Overall, there has been promising research on the value of RCCs for a wide range of social and recovery supports, although there is a clear need for more methodologically rigorous studies aligned with fidelity.

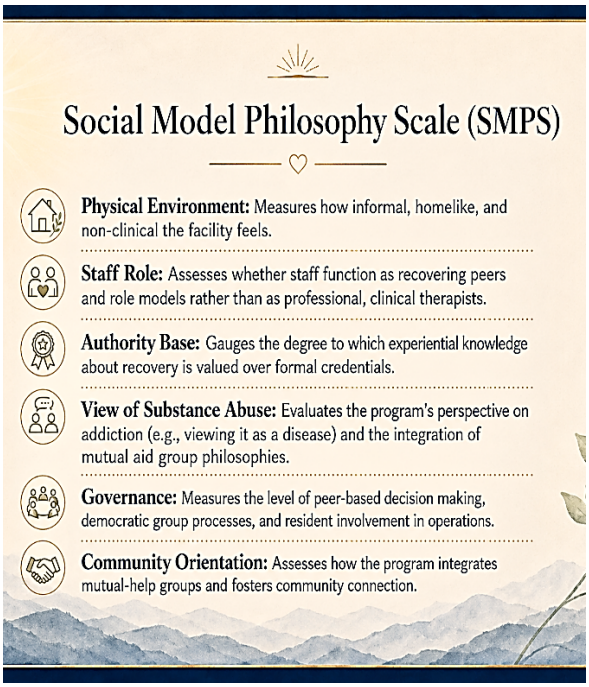
Research on the effectiveness of the Social Element within Recovery Community Centers

With modest research on Recovery Community Centers, it is important to also consider the research on the three primary components of RCCs. Recovery Community Centers house three primary features:

- **Social Venue**: drop-in center, hangout, mutuality, events, activities
- **Mutual Aid Meetings**: 12-step, SMART, Wellbriety, Refuge Recovery, etc.
- **Non-Clinical Peer Delivered Services**: certified peers provide mental and emotional support, hope, motivation, system navigation, linkages to resources, etc.

The Social Model of Recovery is a nonclinical, community-based approach to substance use recovery that emphasizes peer support, shared lived experience, mutual aid, community participation, personal responsibility, recovery-supportive environments, and helping relationships. Rather than viewing recovery as something delivered primarily by professionals, the social model views recovery as something people build through relationships, roles, routines, identity, belonging, and community connection.

The Social Model of Recovery is best understood as a philosophy of care rather than a single manualized intervention. It is rooted in A.A./12-step traditions and emphasizes lived experience as a source of authority, peer reciprocity, participant responsibility and governance, an egalitarian physical environment, and connection to the wider recovery community. Researchers often operationalize it with the Social Model Philosophy Scale (SMPS), which measures six domains. The scale was created by the Alcohol Research Group in the 1990s as a research assessment tool, after researchers observed: that many recovery homes and treatment programs were slowly dropping their social model characteristics as a result of moving towards a mandated treatment and recovery system.



Most studies that have included research regarding the Social Model of Recovery have been limited to studies of treatment programs, recovery housing, 12-step attendance, and peer delivered services.

Kaskutas and colleagues (2004) performed a large California naturalistic study of 722 clients finding that people in social-model programs were less likely than those in clinical-model programs to report alcohol or drug problems at one year, although other problem domains were similar.

In a randomized trial of 271 people, a community social-model day program with strong fidelity produced abstinence outcomes and average costs similar to hospital day treatment while a weaker-fidelity community program performed worse.

A later clinical trial of 733 treatment-seeking individuals found no significant abstinence differences between day treatment and community-based social-model care. Taken together, the strongest head-to-head studies suggest social-model services can perform at

least as well as clinical programs on abstinence, and sometimes better on substance-use outcomes, but the number of rigorous comparative trials is still limited.

Much of the newer evidence comes from settings that embody social-model principles, rather than from studies that focus on measuring the effectiveness of the social model as a whole. A systematic review of peer recovery support services by Eddie and colleagues (2025) identified 28 multi-group studies with 12,601 participants and concluded that these services improve treatment engagement and retention. However, evidence for direct improvements in substance use remains preliminary and inconclusive.

Recovery housing has the clearest contemporary evidence among social-model settings. A 2025 systematic review found five comparative studies, three randomized controlled trials, and two quasi-experimental studies, and found that recovery housing outperformed continuing care or no housing on abstinence, income, employment, and some criminal-justice outcomes, and it was more cost-effective.

A 2023 review also summarized large sober-living-house studies showing improvements in substance use, psychiatric symptoms, employment, and arrest rates, and found that stronger recovery house social environments were associated with longer stays and fewer days of substance use.

While little research has examined the effectiveness of Recovery Community Centers, a large and growing body of research supports peer-delivered services and participation in mutual aid. For example, a 2020 Cochrane review of rigorous research studies performed on Alcoholics Anonymous and 12-step facilitation found it to be effective for alcohol use disorder, and highlighted associations with improved rates of abstinence and lowered healthcare costs.

Despite a lack of rigorous research trials, the current evidence base for Recovery Community Centers is positive and indicates that the model is likely as effective as standard clinical treatment approaches for substance use and, in many cases, more cost-effective.

Overall, Recovery Community Centers are a promising model of SUD recovery services that contribute to improved individual, interpersonal, and community outcomes, which warrant increased attention, research, and funding.

The Alcohol & Drug Policy Commission has put forward the following definition of Recovery Community Centers:

Recovery Community Center Definition

A Recovery Community Center is a non-residential, peer-operated center, usually with a paid director and recovery staff. A Recovery Community Center offers drop-in hours, peer support, recovery and social support services. Participants in Recovery Community Centers are youth and adults experiencing challenges or obstacles consistent with recovery from a substance use disorder (SUD), or those in remission from such obstacles. These individuals participate in center activities and services and are engaging in the recovery process. Recovery Community Center services are typically free of charge to participants. If a Recovery Community Center does not offer culturally specific services specific to an individual's needs, the center must be able to refer them to such available services.

A Recovery Community Center is designed to help participants build recovery capital (i.e., resources available to an individual that can aid in SUD recovery) by sponsoring social activities with other individuals in SUD recovery, fostering relationships among individuals in SUD recovery, navigating community resources and connection to social services, hosting mutual support meetings, connection to employment resources and opportunities, advocacy education, and volunteer opportunities.

Tony Vezina, BSW, CADC-I, CRM-II, Debi Elliot, Ph.D. & Jerrod Murray, CADC-I, CRM-II

DOMAIN I: RECOVERY COMMUNITY CENTER FOUNDATIONS, PHILOSOPHY, & GOVERNANCE

☐ RCCs operate as peer-governed, community-based recovery centers that are distinct from state-licensed clinical treatment centers. RCCs clearly define their mission, scope of peer services, and referral thresholds in both policy and public communications.

Staff Competencies	
☐	Staff accurately communicate RCC mission, scope of peer services, and referral pathways.
☐	Staff maintain clear peer support role boundaries distinct from clinical services.

Best Practice 2:

The Foundations of Recovery Community Centers include; facilitating The Social Model of Recovery, hosting Mutual Aid Meetings, and providing Peer Services

The Social Model of Recovery

☐ RCCs facilitate the Social Model of Recovery, in which participants provide mutual peer support to one another while engaging in recovery and social activities. RCCs understand their unique status as a hub for alcohol and drug-free social recovery, while simultaneously practicing consistent boundary management in the social venue. RCCs foster hospitality, dignity, warmth, and inclusion, and are welcoming and hospitable to all individuals seeking recovery.

Staff Competencies	
☐	Staff demonstrate knowledge of the value of the Social Model of Recovery and facilitate mutuality, participant-to-participant recovery connection, and support.
☐	Staff understand the unique nature of working in a casual social club-like setting (vs. clinical setting) and practice confidentiality and boundary management.

Hosting Mutual Aid Meetings

☐ RCCs maintain a distinction from the mutual aid support groups that they host. RCCs serve all individuals seeking recovery and formally adopt policies affirming multiple recovery pathways, including abstinence-based, medication-supported, faith-based, secular, mutual-aid, and wellness-oriented models. RCCs strive to offer many available pathways to recovery and avoid bias towards a single pathway.

Staff Competencies	
☐	Staff maintain clear distinction between RCC services and hosted mutual-aid groups.
☐	Staff understand, affirm and host varied recovery pathways without bias.

Peer Services

☐ RCCs provide goal-oriented individual peer coaching and structured peer groups. Peers practice fidelity to the peer services model based on nationally recognized practice standards, core competencies of the peer profession, certification standards, and Core Competencies for Peer Workers (SAMHSA, IC&RC, & MHA).

Staff Competencies	
☐	Staff provide goal-oriented, person-directed peer services to identify goals, build recovery capital, and take self-directed steps towards recovery.
☐	Staff deliver peer coaching aligned with recognized peer practice standards, certification expectations, and core peer competencies.

Best Practice 3: Recovery Community Centers operate within Recovery-Oriented Systems of Care (ROSC)

☐ RCCs align programming with ROSC principles emphasizing long-term recovery management, continuity of support, and integration across behavioral health, housing, employment, and restorative justice systems. Local RCCs routinely assess gaps in the ROSC continuum within their communities, fill gaps when able and advocate on behalf of participants and their systemic needs.

Staff Competencies	
☐	Staff connect participants to coordinated recovery supports across systems.
☐	Staff identify community system gaps, fill gaps and advocate for participant needs.

Best Practice 4: Recovery Community Centers Facilitate Participatory Governance & Ownership

☐ RCCs center lived-experience in decision-making, leadership, and daily operations. They create participant-driven environments by avoiding staff-centric practices, over-staffing, and over-policing the center, all of which can reduce community ownership and participant voice. Instead, RCCs promote safety, inclusion, volunteerism,

and meaningful opportunities for participants to shape the center's culture, activities, and direction. RCCs provide pathways for members to assume governance, facilitation, and advocacy roles.

Staff Competencies	
☐	Staff create opportunities for participants to shape RCC decisions, activities, culture, and operations.
☐	Staff support inclusion, volunteerism, and participant pathways into leadership, facilitation, governance, and advocacy.

☐ RCCs provide open, drop-in, voluntary participation without diagnostic intake or financial barriers. Unlike clinical settings that require an active diagnosis and "medical necessity", RCCs routinely encounter and serve the individuals experiencing the entire substance use disorder spectrum (DSM-5-TR: mild, moderate, severe, use, intoxication, withdrawal, early or sustained remission) and do not require a clinical diagnosis for participation. RCCs maintain calm, substance-free, and physically safe spaces. Hours of operation and programming are consistent, regular, familiar and accessible outside of normal business hours. RCCs acknowledge and address disparities, serve diverse populations and are culturally responsive. RCC's recognize limits of cultural responsiveness and partner with culturally specific organizations to provide culturally specific services.

Staff Competencies	
☐	Staff exhibit hospitality, welcoming participants through open, voluntary, drop-in access.
☐	Staff maintain consistent, calming, substance-free spaces that are physically safe, culturally responsive, and accessible beyond typical business hours.

DOMAIN II: RECOVERY SUPPORT SERVICE ACTIVITIES

☐ RCCs help people cultivate recovery capital by strengthening the personal, social, practical, cultural, and community resources needed to sustain recovery. This includes supporting health, coping skills, hope, purpose, and resilience; fostering supportive relationships and accountability; connecting people to basic needs such as

housing, food, transportation, employment, and financial skills; affirming cultural identity and recovery-supportive values; and improving access to services, healthcare, and recovery-friendly community supports.

Staff Competencies	
☐	Staff identify strengths and needs across personal, social, practical, cultural, and community recovery supports.
☐	Staff link individuals to basic needs, healthcare, employment, peer support, and recovery-friendly community resources.

☐ RCCs provide transitional employment, supported employment, and workforce readiness supports. RCCs build relationships with employers within the community, including "felony friendly" employers and making referrals.

Staff Competencies	
☐	Staff help participants build employment skills and access transitional or supported employment opportunities.
☐	Staff make connections and build relationships with recovery-friendly and felony-friendly employers, vocational training programs, and employment services and make appropriate job referrals.

☐ RCCs promote recovery identity and abstinent social networks for all individuals seeking to initiate and sustain recovery. RCCs facilitate relationships within the center's internal recovery community, where those with long-term recovery support new participants. RCCs offer scheduled recreational, educational, and volunteer activities that replace high-risk routines. These pro-social activities promote the values of recovery by guiding new members and practicing the principles of honesty, hope, and compassion.

Staff Competencies	
☐	Staff help participants develop recovery identity, supportive relationships, and sober abstinent networks.
☐	Staff organize recovery-focused recreational, educational, and volunteer activities that promote honesty, hope, compassion, and mutual peer support.

☐ RCCs integrate overdose prevention and other strategies to minimize risks associated with return to use within recovery supports where appropriate. RCCs are adept at promoting both abstinence-based recovery and relapse risk management practices simultaneously.

Staff Competencies	
☐	Staff demonstrate knowledge regarding evidence-based overdose prevention and relapse risk management strategies and interventions.
☐	Staff understand the continuum of risk management and abstinence-based approaches and can implement both simultaneously.

☐ RCCs integrate families into recovery processes when appropriate by supporting their specialized needs, including hosting mutual aid groups serving family members and significant others of persons with substance use challenges.

Staff Competencies	
☐	Staff make contact with families and significant others when appropriate and with the participant's consent to support the recovery process.
☐	Staff connect parents, families, and significant others to education, mutual aid, and recovery-supportive resources.

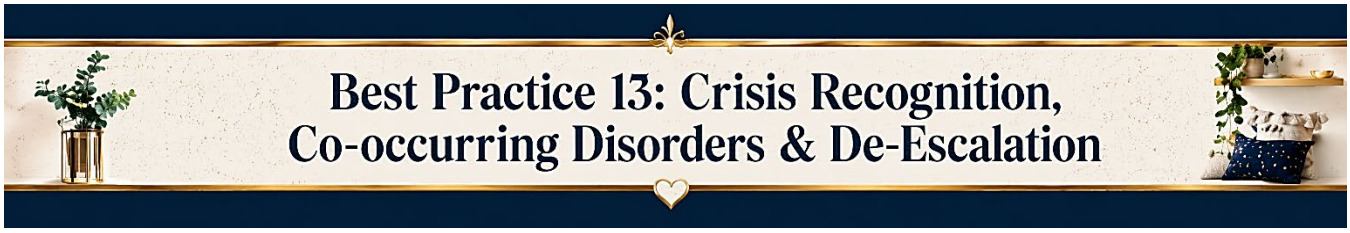
☐ RCCs recognize the emotional, psychosocial, and cognitive developmental stages and disabilities of the individuals they serve. Peers understand developmental assets, resilience, and protective factors in adults from age 18 through the lifespan, providing responsive and supportive services based on that knowledge.

Staff Competencies	
☐	Staff understand developmental stages, disabilities, strengths, resilience, and protective factors across the lifespan.
☐	Staff adapt peer services to each participant's developmental, cognitive, emotional, and psychosocial needs.

☐ RCCs monitor the engagement of participants enrolled in professional peer services, as well as attendance patterns and day-level fluctuations in recovery risks. RCCs understand average attendance patterns and how engagement is impacted by transportation, childcare, employment, physical and mental health, and other obligations. RCCs do not place unrealistic expectations on individuals, e.g., 90 meetings in 90 days, recognizing that each participant has different capacities and limitations.

Staff Competencies	
☐	Staff track attendance, participation, and fluctuations in recovery risk for participants enrolled in professional peer services.
☐	Staff recognize barriers to engagement, including transportation, childcare, employment, and health needs, and assist individuals in overcoming these challenges.

DOMAIN III: CRISIS AND BRIDGE SERVICES



☐ The primary focus of RCCs is substance use recovery support; however, RCCs recognize the essential need to address co-occurring disorders. Peer staff provide non-clinical mental health peer support and, when necessary, assist in coordinating referrals to clinical mental health agencies or other mental health-focused recovery supports (e.g., NAMI, Clubhouses, Living Rooms). RCCs foster a culture of safety by training staff to recognize when a participant may be in crisis and to respond with compassion, lived experience, Mental Health First Aid, grounding techniques, and collaborative, person-driven planning. RCCs understand when a situation requires support beyond what the center or peer can safely provide. In those moments, they walk alongside the individual to connect them with mobile crisis teams, clinical providers, or other appropriate partners. Whenever safely possible, RCCs prioritize peer-led de-escalation over law enforcement involvement in order to maintain a healing, non-punitive environment. RCCs use restorative practices, role modeling, and relationship-based conflict resolution to help address harm while ensuring every participant has a path to remain connected to the community.

Staff Competencies	
☐	Staff recognize co-occurring mental health needs, crisis signs, and safety concerns, then respond with compassion, grounding, de-escalation, and person-driven support.
☐	Staff identify service gaps, engage at-risk and vulnerable communities, and connect individuals to wellness, recovery, and community supports.

☐ RCCs serve as low-barrier community spaces where individuals can walk in and receive immediate peer support, connection, and navigation. They support people who are transitioning from a range of settings, including clinical treatment, withdrawal management, incarceration, psychiatric hospitalization, crisis stabilization, and other systems of care. By listening closely to the community, RCCs identify where individuals are falling through the cracks and build bridges to the services and supports they need across the eight dimensions of wellness, including housing, employment, mental health care, and recovery support. RCCs also engage in outreach by going where the need is greatest, and connecting with those who may be vulnerable, at risk, or in need of immediate support. Through these efforts, RCCs provide both an immediate bridge and an ongoing peer relationship that helps individuals build recovery capital, stay connected to community, and sustain a life in recovery.

Staff Competencies	
☐	Staff offer immediate peer support, connection, and navigation for individuals transitioning from treatment, crisis, incarceration, or other systems.
☐	Staff identify service gaps, engage people where needs are greatest, and connect individuals to wellness, recovery, and community supports.

DOMAIN V: OPERATIONS, FIDELITY & INFRASTRUCTURE

☐ RCCs maintain; legitimate business operations, secretary of state business registration, submission of annual 990s and charitable trust reports, GAAP accounting, fiscal controls, annual budgets, diversified funding, nonprofit board oversight with meeting minutes, accreditation alignment, employee payroll, HR employee policies and procedures, support for employee education and peer credentialing, maintenance of public access building codes, compliance with city code and fire marshal regulations, and overall infrastructure stability.

Staff Competencies	
☐	Staff maintain required business registrations, reporting, accreditation alignment, policies, records, and facility compliance.
☐	Staff support sound budgeting, fiscal controls, diversified funding, board oversight, HR systems, and workforce development.

☐ RCCs track participation rates, recovery capital indicators, quality of life, and member satisfaction. RCCs solicit comprehensive community feedback to improve service, measure satisfaction, identify gaps, and understand community demographics, trends, and needs. RCCs maintain fidelity to core peer recovery principles while adapting services to local needs.

Staff Competencies	
☐	Staff collect and review participation, recovery capital, quality of life, and participant satisfaction data.
☐	Staff use community feedback and service data to identify gaps, adapt services, and maintain fidelity to peer recovery principles.

☐ RCCs provide structured training, supervision, certification pathways, career ladders, and overall employee wellness supports.

Staff Competencies	
☐	Staff participate in training, supervision, certification, and career growth opportunities.
☐	Staff utilize wellness supports and supervision to maintain ethical, effective, and sustainable peer practice.

☐ Some RCCs tailor programming and operations that support specific populations, including adolescent, veteran, culturally specific, LGBTQIA+, etc. Specialized recovery centers are developed, supervised, and operated by members of that population. Specialized RCCs develop policies, procedures, and practices that support the specific needs of their populations. Youth-oriented RCCs provide both substance use and mental health peer services. Youth-oriented RCCs serve whole families as well as identified youth.

Staff Competencies	
☐	Staff in specialty RCCs adapt services, programming, and practices to meet the needs of specific populations.
☐	Staff support services that are developed, supervised, and led by members of the populations served.

Review Form

Best Practices and Staff Competencies	Does not meet standard of practice	Partially meets standard of practice	Fully meets standard of practice
Best Practice 1: Recovery Community Centers are Peer-Led with a Non-Clinical Identity	Score-1 ☐	Score-2 ☐	Score-3 ☐
Staff accurately communicate RCC mission, scope of peer services, and referral pathways.			
Staff maintain clear peer support role boundaries distinct from clinical services.			
Best Practice 2: The Foundations of Recovery Community Centers include; facilitating The Social Model of Recovery, hosting Mutual Aid meetings, and providing Peer Services	Score-1 ☐	Score-2 ☐	Score-3 ☐
Staff demonstrate knowledge of the value of the Social Model of Recovery and facilitate mutuality, participant-to-participant recovery connection, and support.			
Staff understand the unique nature of working in a casual social club-like setting (vs. clinical setting) and practice confidentiality and boundary management.			
Staff maintain clear distinction between RCC services and hosted mutual-aid groups.			
Staff understand, affirm and host varied recovery pathways without bias.			
Staff provide goal-oriented, person-directed peer services to identify goals, build recovery capital, and take self-directed steps towards recovery.			
Staff deliver peer coaching aligned with recognized peer practice standards, certification expectations, and core peer competencies.			
Best Practice 3: RCCs operate within Recovery-Oriented Systems of Care (ROSC)	Score-1 ☐	Score-2 ☐	Score-3 ☐
Staff connect participants to coordinated recovery supports across systems.			
Staff identify community system gaps, fill gaps and advocate for participant needs.			
Best Practice 4: Recovery Community Centers Facilitate Participatory Governance & Ownership	Score-1 ☐	Score-2 ☐	Score-3 ☐
Staff create opportunities for participants to shape RCC decisions, activities, culture, and operations.			
Staff support inclusion, volunteerism, and participant pathways into leadership, facilitation, governance, and advocacy.			
Best Practice 5: RCCs provide Low-Barrier, Voluntary Access to a Safe Predictable Environment	Score-1 ☐	Score-2 ☐	Score-3 ☐

Staff exhibit hospitality, welcoming participants through open, voluntary, drop-in access.			
Staff maintain consistent, calming, substance-free spaces that are physically safe, culturally responsive, and accessible beyond typical business hours.			
Best Practice 6: RCCs build Recovery Capital	Score-1 ☐	Score-2 ☐	Score-3 ☐
Staff identify strengths and needs across personal, social, practical, cultural, and community recovery supports.			
Staff link individuals to basic needs, healthcare, employment, peer support, and recovery-friendly community resources.			
Best Practice 7: RCCs feature Employment as Central to Recovery	Score-1 ☐	Score-2 ☐	Score-3 ☐
Staff help participants build employment skills and access transitional or supported employment opportunities.			
Staff make connections and build relationships with recovery-friendly and felony-friendly employers, vocational training programs, and employment services and make appropriate job referrals.			
Best Practice 8: RCCs facilitate Recovery Identity and Belonging	Score-1 ☐	Score-2 ☐	Score-3 ☐
Staff help participants develop recovery identity, supportive relationships, and sober abstinent networks.			
Staff organize recovery-focused recreational, educational, and volunteer activities that promote honesty, hope, compassion, and mutual peer support.			
Best Practice 9: RCCs integrate Risk Reduction & Health Promotion Principles	Score-1 ☐	Score-2 ☐	Score-3 ☐
Staff demonstrate knowledge regarding evidence-based overdose prevention and relapse risk management strategies and interventions.			
Staff understand the continuum of risk management and abstinence-based approaches and can implement both simultaneously.			
Best Practice 10: RCCs incorporate Families and promote Parental Supports	Score-1 ☐	Score-2 ☐	Score-3 ☐
Staff make contact with families and significant others when appropriate and with the participant's consent to support the recovery process.			
Staff connect parents, families, and significant others to education, mutual aid, and recovery-supportive resources.			
Best Practice 11: RCCs provide Developmentally Responsive Services	Score-1 ☐	Score-2 ☐	Score-3 ☐
Staff understand developmental stages, disabilities, strengths, resilience, and protective factors across the lifespan.			
Staff adapt peer services to each participant’s developmental, cognitive, emotional, and psychosocial needs.			
Best Practice 12: RCCs monitor and support Engagement	Score-1 ☐	Score-2 ☐	Score-3 ☐
Staff track attendance, participation, and fluctuations in recovery risk for participants enrolled in professional peer services.			
Staff recognize barriers to engagement, including transportation, childcare, employment, and health needs, and assist individuals in overcoming these challenges.			
Best Practice 13: Crisis Recognition, Co-occurring Disorders & De-Escalation	Score-1 ☐	Score-2 ☐	Score-3 ☐
Staff recognize co-occurring mental health needs, crisis signs, and safety concerns, then respond with compassion, grounding, de-escalation, and person-driven support.			

Staff identify service gaps, engage at-risk and vulnerable communities, and connect individuals to wellness, recovery, and community supports.			
Best Practice 14: Bridge & Transition Services Staff offer immediate peer support, connection, and navigation for individuals transitioning from treatment, crisis, incarceration, or other systems. Staff identify service gaps, engage people where needs are greatest, and connect individuals to wellness, recovery, and community supports.	Score-1 ☐	Score-2 ☐	Score-3 ☐
Best Practice 15: Organizational Sustainability Staff maintain required business registrations, reporting, accreditation alignment, policies, records, and facility compliance. Staff support sound budgeting, fiscal controls, diversified funding, board oversight, HR systems, and workforce development.	Score-1 ☐	Score-2 ☐	Score-3 ☐
Best Practice 16: Data-Informed Continuous Quality Improvement & Fidelity Staff collect and review participation, recovery capital, quality of life, and participant satisfaction data. Staff use community feedback and service data to identify gaps, adapt services, and maintain fidelity to peer recovery principles.	Score-1 ☐	Score-2 ☐	Score-3 ☐
Best Practice 17: Workforce Development & Supervision Staff participate in training, supervision, certification, and career growth opportunities. Staff utilize wellness supports and supervision to maintain ethical, effective, and sustainable peer practice.	Score-1 ☐	Score-2 ☐	Score-3 ☐
Best Practice 18: RCCs & Specialty Populations Staff in specialty RCCs adapt services, programming, and practices to meet the needs of specific populations. Staff support services that are developed, supervised, and led by members of the populations served.	Score-1 ☐	Score-2 ☐	Score-3 ☐

Score Range 18-54

Does not meet standards of practice	Partially meets standards of practice	Fully meets standards of practice
18	**36**	**54**

References

1. Alanoclubs.org. (n.d.). *About Alano clubs*. https://alanoclubs.org/home/
2. Alcoholics Anonymous Grapevine. (1951, February). *Survival of the fittest 24 hour club*.
3. Alcoholics Anonymous. (n.d.). *Guidelines: Relationship between A.A. and clubs (MG-03).* Alcoholics Anonymous World Services.
4. Apsley, H. B., Ren, W., Lancaster, J., Brick, T. R., & Cleveland, H. H. (2025). Recovery community center visits and activities: A description using a daily diary approach. *Alcoholism Treatment Quarterly, 43*(1), 3–12. https://doi.org/10.1080/07347324.2024.2415595
5. Apsley, H. B., Lancaster, J., Ren, W., Brick, T. R., & Cleveland, H. H. (2025). Experiences at recovery community centers predict holistic recovery outcomes: A daily diary assessment of RCC helpfulness, meaningfulness, and recovery identity. *Frontiers in Public Health, 12*, Article 1476441. https://doi.org/10.3389/fpubh.2024.1476441
6. Association of Recovery Community Organizations. (2023). *National standards of best practices for recovery community organizations.*
7. Association of Recovery Community Organizations. (n.d.). *CAPRSS: RCCs and accreditation—A national perspective*.
8. Ashford, R. D., Brown, A. M., Dorney, G., McConnell, N., Kunzelman, J., McDaniel, J., & Curtis, B. (2019). Reducing harm and promoting recovery through community-based mutual aid: Characterizing those who engage in a hybrid peer recovery community organization. *Addictive Behaviors, 98*, Article 106037. https://doi.org/10.1016/j.addbeh.2019.106037
9. Ashford, R. D., Curtis, B., & Brown, A. M. (2018). Peer-delivered harm reduction and recovery support services: Initial evaluation from a hybrid recovery community drop-in center and syringe exchange program. *Harm Reduction Journal, 15*(1), Article 52. https://doi.org/10.1186/s12954-018-0258-2
10. Associated Press. (2024, June 5). Clubhouse programs take pressure off overwhelmed Texas mental health hospitals. *AP News*. https://apnews.com/ it's
11. Balint, A. (2022). *Words from the café: Voices of people in recovery*. Recovery Café.
12. Bernier, L. B., Foley, J. D., Salomaa, A. C., Scheer, J. R., Kelly, J., Hoeppner, B., & Batchelder, A. W. (2024). Examining sexual minority engagement in recovery community centers. *Journal of Substance Use and Addiction Treatment, 161*, 209340. https://doi.org/10.1016/j.josat.2024.209340
13. Best, D., Beckwith, M., Haslam, C., Haslam, S. A., Jetten, J., & Lubman, D. I. (2015). Overcoming alcohol and other drug addiction as a process of social identity transition: The Social Identity Model of Recovery. *Addiction Research & Theory, 24*(2), 111–123.
14. Bohler, R. M., Lofaro, R. J., Smith, K. D., Johnson, J. A., Shehaj, B., Kite, B., & Mase, W. A. (2025). Bridging the gaps: Rural recovery community centers and their role in addressing substance use disorders. *Journal of Rural Health, 41*(4), Article e70084. https://doi.org/10.1111/jrh.70084
15. CASA-Trinity. (n.d.). *AIR youth clubhouses*. https://casa-trinity.org/recovery/our-air-youth-clubhouses/
16. Circana. (2025). *Alcohol statistics 2025: Sober curious nation & beverage trends*. https://www.circana.com/post/sober-curious-nation-alcohol-survey
17. Clubhouse International. (2020). *International standards for clubhouse programs*. https://www.clubhouse-intl.org
18. Columbia County Pathways to Recovery. (n.d.). *Youth clubhouses of Hudson & Catskill*. https://www.columbiagreeneaddictioncoalition.org/prevention
19. Curly Tales. (2023). *How alcohol-free venues & sober bars are transforming nightlife across America's cities*. https://curlytales.com
20. Dangwung, P., Golden, K., Webb, A., Fredrick, M., & Roberts, D. L. (2024). The UT Health Living Room: Expanding the psychiatric crisis continuum of care. *Community Mental Health Journal, 60*(8), 1589–1595. https://doi.org/10.1007/s10597-024-01238-4
21. DeCristofaro, D., Futter, A., Williamson, A. C., Hoeppner, S. S., Hoffman, L. A., Riggs, M. J., Joseph, J., Ojeda, J., Mericle, A. A., Rao, V., Rutherford, P. X., McCarthy, P., & Hoeppner, B. B. (2025). Comparing recovery community centers (RCCs) serving Black, Hispanic/Latino, and other

communities: An exploratory secondary data analysis of a nationwide survey of RCC directors. *Frontiers in Public Health, 13*, 1532488. https://doi.org/10.3389/fpubh.2025.1532488

22. Demetrius, A., Davis, Y. J., & Wilson, S. (2010). Peers reach out supporting peers to embrace recovery (PROSPER): A center for substance abuse treatment recovery community services program. *Alcoholism Treatment Quarterly, 28*(3), 326–338. https://doi.org/10.1080/07347324.2010.488538
23. Dewey, J. M., Gallardo, K. R., Subbaraman, M. S., & Mericle, A. A. (2026). "If he did it, I can do it, too. I can change my life around": The social model of recovery within the context of recovery homes accepting residents prescribed medications for opioid use disorder. *Journal of Substance Use and Addiction Treatment, 180*, 209830. https://doi.org/10.1016/j.josat.2025.209830
24. American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.).
25. Dingle, G. A., Cruwys, T., & Frings, D. (n.d.). Social identity and recovery: Qualitative research on social identity transitions in addiction recovery.
26. Duffy, K., Campbell, J., & Gill, D. (2011). Serenity Café: On the road to recovery capital. *Journal of Groups in Addiction & Recovery, 6*(1–2), 39–56. https://doi.org/10.1080/1556035X.2011.571131
27. Faces & Voices of Recovery. (2012). *Recovery community organization toolkit*.
28. Faces & Voices of Recovery. (2012). *Vision, mission, and principles for recovery community organizations*.
29. Fifty Grande. (2023). *Best zero-proof and alcohol-free bars in America*. https://www.fiftygrande.com/best-zero-proof-and-alcohol-free-bars-in-america/
30. Food Institute. (2023). *Study: Most Americans are interested in sober bars*. https://foodinstitute.com/focus/study-most-americans-are-interested-in-sober-bars/
31. Fountain House. (2022). *Evidence supporting the clubhouse model*.
32. Fountain House. (2023). *Beyond treatment: The clubhouse model of psychosocial rehabilitation as community-based social support*. https://www.fountainhouse.org/reports/beyond-treatment
33. Friends of Recovery–New York. (n.d.). *Youth clubhouses*. https://for-ny.org/youth-clubhouses/
34. Friends of Recovery–Delaware/Otsego (FOR-DO). (n.d.). *Club Odyssey youth clubhouse*. https://for-do.org/club-odyssey/
35. Georgia Department of Behavioral Health and Developmental Disabilities. (2015, May 7). Youth clubhouses provide safe and supportive environments across Georgia. *DBHDD Blog*. https://dbhdd.org/blog/2015/05/07/youth-clubhouses-provide-safe-and-supportive-environments-across-georgia/
36. Georgia Department of Behavioral Health and Developmental Disabilities. (2019, December 16). *Georgia behavioral health system overview*.
37. Georgia Department of Behavioral Health and Developmental Disabilities. (2020). *Addiction recovery support centers*.
38. Georgia Department of Behavioral Health and Developmental Disabilities. (2021). *Mental health resiliency support clubhouses*.
39. Georgia Department of Behavioral Health and Developmental Disabilities. (n.d.). *Adolescent services: Recovery support clubhouse*. https://dbhdd.georgia.gov/be-supported/help-substance-abuse/adolescent-services
40. Georgia Department of Behavioral Health and Developmental Disabilities. (n.d.). *Clubhouses*.
41. Georgia Health Policy Center. (n.d.). *Recovery support clubhouses*. Georgia State University. https://ghpc.gsu.edu/project/recovery-support-clubhouses/
42. Good Morning America. (2021). Alcohol-free bar in Texas fuels the growing "sober-curious" movement. *ABC News*. https://abcnews.go.com/
43. Grasmere, J., Martell, J., Andersen, R., & Parker, D. (2006). *How to build your own peer-to-peer recovery center from the ground up!*
44. Gregitis, S., Glacken, J., Julian, C., & Underwood, K. (2010). Comparing working role values of employed and unemployed Clubhouse members. *Work, 36*(1), 39–46. https://doi.org/10.3233/WOR-2010-1089
45. Guttman, M. (2018). The living room model in practice: Inside HDSW of Westchester. *Human Development Services of Westchester Blog*. https://www.hdsw.org
46. Haberle, B. J., Conway, S., Valentine, P., Evans, A. C., White, W. L., & Davidson, L. (2014). The recovery community center: A new model for volunteer peer support to promote recovery.

Journal of Groups in Addiction & Recovery, 9(3), 257–270. https://doi.org/10.1080/1556035X.2014.908875

47. Heyland, M., Emery, C., & Shattell, M. (2013). The living room: A community crisis respite program offering people in crisis an alternative to emergency departments. *Global Journal of Community Psychology Practice, 4*(3), 1–8.
48. Heyland, M., & Johnson, M. (2017). Evaluating an alternative to the emergency department for adults in mental health crisis. *Issues in Mental Health Nursing, 38*(7), 557–561. https://doi.org/10.1080/01612840.2017.1300797
49. Highland Rivers Behavioral Health. (n.d.). *Substance use recovery clubhouses*.
50. Hill, F. (1953). *The 24-hour club for alcoholics*. *Your Life*, January 1953. https://silkworth.net/
51. Hill, T. (2020). *The origins of recovery community centers: Context and history*. National Council for Behavioral Health. https://www.recoveryanswers.org/assets/The-Origins-of-Recovery-Community-Centers.pdf
52. Hoeppner, B. B., Williamson, A. C., Simpson, H., DeCristofaro, D., Weerts, C., Riggs, M. J., Futter, A., Mericle, A. A., Rutherford, P. X., McCarthy, P., Ojeda, J., & Hoeppner, S. S. (2025). How to measure the effectiveness of recovery community centers: Insights gained from a nationwide survey of directors of RCCs. *Frontiers in Public Health, 13*, 1532812. https://doi.org/10.3389/fpubh.2025.1532812
53. Hoeppner, B. B. (n.d.). *Advancing the science on recovery community centers*. Health Through Flourishing.
54. Hoffmann, H. C. (2006). Criticism as deviance and social control in Alcoholics Anonymous. *Journal of Contemporary Ethnography, 35*(6), 669–695.
55. Idaho Department of Health & Welfare. (2020). *Defining behavioral health crisis centers vs. recovery community centers*. Recovery Versus Crisis Centers.
56. ImpactLife. (2020). *Recovery community centers*. https://impactlifetoday.org/rcc/
57. Indiana University School of Public Health and the Center for Rural Engagement. (n.d.). *Recovery community centers: Centralized support for mental health and substance use disorders.* https://scholarworks.iu.edu/iuswrrest/api/core/bitstreams/d0a79724-ded7-416a-9e53-e4073df2911d/content
58. Kaplan, L., Nugent, C., Baker, M., Clark, H. W., & Veysey, B. M. (2010). Introduction: The recovery community services program. *Alcoholism Treatment Quarterly,* 28(3), 244–255. https://doi.org/10.1080/07347324.2010.488522
59. Kaskutas, L. A., Ammon, L., & Weisner, C. (2003–2004). A naturalistic comparison of outcomes at social and clinical model substance abuse treatment programs. *International Journal of Self Help & Self Care*, *2*(2), 111–133. https://doi.org/10.2190/CK88-84XD-PRGE-0B1P
60. Kelly, J. F., Fallah-Sohy, N., Cristello, J., Stout, R. L., Jason, L. A., & Hoeppner, B. B. (2021). Recovery community centers: Characteristics of new attendees and longitudinal investigation of the predictors and effects of participation. *Journal of Substance Abuse Treatment*, 124, 108287. https://doi.org/10.1016/j.jsat.2021.108287
61. Kelly, J. F., Fallah-Sohy, N., Vilsaint, C. L., Hoffman, L. A., Jason, L. A., Stout, R. L., Cristello, J., & Hoeppner, B. B. (2020). New kid on the block: An investigation of the physical, operational, personnel, and service characteristics of recovery community centers in the United States. *Journal of Substance Abuse Treatment*, *111*(1–10). https://doi.org/10.1016/j.jsat.2019.12.009
62. Kelly, J. F., O'Connor, J. B., Klein, M. R., Hoffman, L. A., Eddie, D., Vilsaint, C. L., Bergman, B. G., & Hennessy, E. A. (2025). One-stop shopping for recovery? A systematic review of the evidence on U.S. recovery community centers. *Journal of Substance Use and Addiction Treatment*, *175*, 209723. https://doi.org/10.1016/j.josat.2025.209723
63. Kentucky Opioid Response Effort. (n.d.). Recovery community centers. https://www.chfs.ky.gov/agencies/dbhdid/Documents/recoverycommunitycentersinfograph.pdf
64. Lancaster, J. H., Apsley, H. B., Brick, T. R., Ren, W., & Cleveland, H. H. (2024). The day-level effects of recovery community center attendance on indicators of recovery wellbeing and risk. *Journal of Substance Use and Addiction Treatment, 165*, 209459. https://doi.org/10.1016/j.josat.2024.209459
65. Clark, R., Lance, G., Reid, B., Nguyen, J., McLauchlan, M., & Maningat, K. (2022). *Creative methods for improving health literacy in underserved communities*. Nursing Leadership in

Community Engagement Projects. https://digitalcommons.spu.edu/shs_nlce/15

66. Lugo, N. (2025). The role of community centers in supporting addiction recovery. How Community Centers Enhance Addiction Recovery Support in Houston.
67. Lunnay, B., Nicholls, E., Pennay, A., MacLean, S., Wilson, C., Meyer, S. B., Foley, K., Warin, M., Olver, I., & Ward, P. R. (2022). Sober curiosity: A qualitative study exploring women's preparedness to reduce alcohol by social class. International *Journal of Environmental Research and Public Health*, *19*(22), 14788. https://doi.org/10.3390/ijerph192214788
68. Macias, C., Jackson, R., Schroeder, C., & Wang, Q. (1999). What is a clubhouse? Report on the ICCD 1996 survey of USA clubhouses. *Community Mental Health Journal, 35*(2), 181–190. https://doi.org/10.1023/A:1018776815886
69. Macias, C., Rodican, C. F., Hargreaves, W. A., Jones, D. R., Barreira, P. J., & Wang, Q. (2006). Supported employment outcomes of a randomized controlled trial of ACT and clubhouse models. *Psychiatric Services, 57*(10), 1406–1415. https://doi.org/10.1176/appi.ps.57.10.1406
70. Maffei, J. (2023). Battling addiction: Maine advocates fight for funding for recovery community centers. *WGME*. https://wgme.com/news/local/battling-addiction-maine-advocates-fight-for-funding-for-recovery-community-centers-substance-abuse-state-house-recovery-support-services-bipartisan-support
71. Massachusetts Department of Public Health, & Recovery Research Institute. (2017). *Report of findings from a systematic review of the recovery support services literature*.
72. May, R., Nugent, C., Johnsen, M., Eaton, W., & Lidz, C. (2018). *Peer-run and peer-involved organizations: An overview*.
73. McKay, C., Nugent, K. L., Johnsen, M., Eaton, W. W., & Lidz, C. W. (2018). A systematic review of evidence for the clubhouse model of psychosocial rehabilitation. *Administration and Policy in Mental Health and Mental Health Services Research, 45*(1), 28–47. https://doi.org/10.1007/s10488-016-0760-3
74. McKay, C. (2005). *Recent research findings from the Program for Clubhouse Research* (Issue Brief No. 2(8)). Center for Mental Health Services Research, University of Massachusetts Medical School.
75. Medaris, A. (2022, June 6). How to quit drinking: Sobriety clubs like Tempest draw millennials and Gen Xers. *Business Insider.* https://www.businessinsider.com/how-to-quit-drinking-sobriety-clubs-millennials-tempest-luckiest-club-2022-6
76. Mental Health Association of Columbia–Greene. (n.d.). *Clubhouses: Community-based, peer-driven recovery*. https://www.mhacg.org/programs/clubhouses
77. Mericle, A. A., Cacciola, J. S., Carise, D., & Miles, J. (2014). Supporting recovery in the community: Six-month outcomes of clients participating in the Phoenix House Bronx Community Recovery Center (BCRC). *Journal of Community Psychology, 42*(7), 833–848. https://doi.org/10.1002/jcop.21633
78. Mericle, A. A., Howell, J., Borkman, T., Subbaraman, M. S., Sanders, B. F., & Polcin, D. L. (2023). Social model recovery and recovery housing. *Addiction Research & Theory, 31*(5), 370–377. https://doi.org/10.1080/16066359.2023.2179996
79. Mericle, A. A., Howell, J., McKee, S., Zhang, S. X., & Polcin, D. (2019). Recovery support services in the United States: Recovery community centers. In *Recovery support services in the United States*.
80. Mericle, A. A., Miles, J., Cacciola, J., Howell, J., Zhang, S., & Polcin, D. (2019). Recovery community centers: Characteristics of participants and associations with substance use and well-being.
81. McCarron, M. (2019, January 24). How do nonalcoholic bars actually work? *Eater*. https://www.eater.com/drinks/2019/1/24/18194447/non-alcohol-bars-spirits-free-drinks
82. Mukherjee, D., & Saxon, V. (2019). Psychological boarding and community-based behavioral health crisis stabilization. *Community Mental Health Journal, 55*(5), 771–781. https://doi.org/10.1007/s10597-018-0353-4
83. Murrill, B. (2023). The eighteenth amendment and national prohibition, part 3: Temperance movements. *Congressional Research Service*. https://www.congress.gov/crs-product/LSB10987

84. National Alliance on Mental Illness. (2019–2020). *Responding to crisis: The crisis living room*. https://www.nami.org
85. NAMI Massachusetts. (n.d.). *The living room*. https://www.namimass.org
86. NAMI Metro Suburban. (n.d.). *Understanding crisis response: How NAMI Metro Suburban's living room provides immediate support*. https://www.namimetrosuburban.org
87. NAMI Cook County North Suburban. (n.d.). *The living room: Possible alternative to an emergency room visit*. https://www.namiccns.org
88. National Association of State Mental Health Program Directors. (2023). *The living room*. In *Crisis Stabilization Learning Series*. https://www.nasmhpd.org
89. National Council for Mental Wellbeing. (2021). *Peer recovery support: Evolving roles and settings – A literature review*. National Council for Mental Wellbeing / Peer Recovery Center of Excellence.
90. National Council for Mental Wellbeing. (2023). *Peer recovery support: Evolving roles and settings – A literature review (Year 2 update)*. National Council for Mental Wellbeing/Peer Recovery Center of Excellence.
91. National Institute on Alcohol Abuse and Alcoholism. (2024). Sober-curious young Americans may be changing the conversation around alcohol. *NIAAA Spectrum, 16*(3). https://www.niaaa.nih.gov/
92. New York City Department of Health and Mental Hygiene. (2023). *Clubhouses for people who have serious mental health conditions: A place to go, meaningful things to do, and a lifelong community*.
93. New York State Assembly. (2025). *Bill A5357, 2025–2026 regular session*. https://trackbill.com/bill/new-york-assembly-bill-5357-relates-to-recovery-community-centers/2661593/
94. New York State Office of Addiction Services and Supports. (n.d.). *Youth and young adults: Youth recovery clubhouses*. https://oasas.ny.gov/treatment/youth-and-young-adults
95. Nonacs, R. (2025). A new approach to recovery: Understanding the potential of recovery community centers. *MGH Psychiatry News*. https://www.massgeneral.org/
96. Owens, M. D., Banta-Green, C. J., Newman, A., Marren, R., & Takushi, R. (2023). Insights into a recovery community center model: Results from qualitative interviews with staff and member facilitators from Recovery Café in Seattle, Washington. *Alcoholism Treatment Quarterly, 41*(1), 62–75. https://doi.org/10.1080/07347324.2022.2088323
97. Owens, M. D., & Banta-Green, C. J. (c. 2020–2024). *Recovery Café evaluation*. Addictions, Drug & Alcohol Institute, University of Washington.
98. Page, J., Hawkins, B., Townsend, J., Lewis, S., & Byrne, J. (2022). Leisure constraints experienced by people in early recovery from substance use disorders. *Journal of Substance Use, 27*(3), 315–319.
99. Penn State Social Science Research Institute. (2024). *Recovery community centers linked to support factors for substance use recovery*. Consortium on Substance Use and Addiction. https://ssri.psu.edu/
100. Pernice, F. M., Price, M. H., & Rice, K. (2021). Why we come: Clubhouse members seek connection, purpose and meaning. *Community Mental Health Journal, 57*, 446–456. https://doi.org/10.1007/s10597-020-00675-9
101. Pollard, A. (2023, January 21). 'Sober bars' sell fancy mocktails and business is booming, showing Dry January is more than just a trend. *Business Insider.* https://www.businessinsider.com/sober-bars-booming-across-country-alcohol-free-lifestyle-dry-january-2023-1
102. Sheppard Pratt. (2021). *The landing: Helping young people land in recovery*. https://www.sheppardpratt.org/inspire/story/the-landing-helping-young-people-land-in-recovery/
103. Prince George's County Health Department. (n.d.). *Recovery clubhouse – adolescent*.
104. Prystynska, S. (2021). Colorado's first sober bar offers alternatives to alcohol. *Voice of America*. https://www.voanews.com/
105. RI International. (2016). *Crisis Now model and peer-powered living room settings*. https://www.riinternational.com
106. RI International. (n.d.). *Peer support for the living room setting*. https://www.riinternational.com
107. Recovery Café. (2025). *Final 2024 annual report*. Recovery Café (Seattle). https://recoverycafe.org/wp-

content/uploads/2025/04/Final-2024-Annual-Report.pdf
108. Recovery Café Network. (2017). Recovery Café Network. *Social Innovations Journal, 52*.
109. Recovery Café Network. (2024). *Our 2024 impact report*. https://recoverycafenetwork.org/our-2024-impact-report/
110. Recovery Café Network. (2024). *2024 impact report (brief)*. https://recoverycafenetwork.org/wp-content/uploads/2025/02/2024-Impact-Report-Brief.pdf
111. Recovery Café Network. (n.d.). *Our model*. https://recoverycafenetwork.org/our-model/Recovery Research
112. Institute. (n.d.). Recovery community centers: Is participation in these newer recovery support services associated with better functioning and quality of life? https://www.recoveryanswers.org/
113. Riccio, J. (2017, October 6). Youth clubhouses: Age and developmentally appropriate peer recovery support services in action. New York State Conference, New York, United States.
114. Riske, H. (2023). *How alcohol-free bars are framed to meet consumer demand*. University of Missouri.
115. Saxon, V., Mukherjee, D., & Thomas, D. (2018). Behavioral health crisis stabilization centers: A new normal. *Journal of Mental Health & Clinical Psychology, 2*(3), 1–15.
116. Schartzer, J. E. (1992). Dealing with substance abuse behavior in the clubhouse. *Psychosocial Rehabilitation Journal, 16*(2), 107–110. https://doi.org/10.1037/h0095696
117. Scoles, P. (2023). Social model of recovery: A civic and political right. *Journal of Psychiatry & Mental Health*.
118. Shattell, M. M., Harris, B., Beavers, J., Tomlinson, S. K., Prasek, L., Geevarghese, S., Emery, C. L., & Heyland, M. (2014). A recovery-oriented alternative to hospital emergency departments for persons in emotional distress: "The living room." *Issues in Mental Health Nursing, 35*(1), 4–12. https://doi.org/10.3109/01612840.2013.835012
119. Smith, C. M. (2015). Practice-informed research and evaluation of Georgia's recovery support clubhouses. Georgia Health Policy Center.
120. Smith, C. M., Lee, J., McLaren, S., & Davidson, K. S. (2019). *Evaluation of Georgia's recovery support clubhouses and their impact on substance use and mental health outcomes among youth ages 13–17* (GHPC Materials No. 65). Georgia Health Policy Center, Andrew Young School of Policy Studies, Georgia State University. https://scholarworks.gsu.edu/ghpc_materials/65
121. Substance Abuse and Mental Health Services Administration. (2023). *Counseling approaches to promote recovery from problematic substance use and related issues* (Treatment Improvement Protocol [TIP] Series, No. 65). https://www.ncbi.nlm.nih.gov/books/NBK601481Texas Institute for Excellence in Mental Health. (2019).
122. *Recovery community organizations: An exploration of organizational function and capacity*. University of Texas.
123. The Sober Curator. (2024). *309 Social Club*. https://thesobercurator.com/tag/309-social-club/
124. The Phoenix. (2021). *What's the deal with sober bars?* https://thephoenix.org/resources/whats-the-deal-with-sober-bars/
125. This Naked Mind. (2025). *Sobriety clubs are drawing those who want "freedom from wine o'clock."* https://thisnakedmind.com/sobriety-clubs-the-alcohol-experiment/
126. Valentine, P. (2010). Peer-based recovery support services within a recovery community organization: The CCAR experience. *Addiction recovery management: Theory, research, and practice* (pp. 259–279). Springer.
127. Valentine, P. (2014). Stay in your lane: Distinguishing between a drop-in center, 12-step clubhouse, recovery community center, and addiction treatment center. Connecticut Community for Addiction Recovery.
128. Valentine, P., White, W. L., & Taylor, P. (2007). Recovery community organizations: Toward a working definition and description. Great Lakes Addiction Technology Transfer Center; Philadelphia Recovery Community.
129. Ward, P. R., Savic, M., MacLean, S., Lunnay, B., Lyons, A. C., Hughes, T., London, K., Caluzzi, G., Pettigrew, S., Pennay, A., Meyer, S., Duncan, T., & Lee, N. (2025). Reducing heavy drinking through the "sober curious" movement in Australia: Protocol for a mixed methods study. *JMIR*

Research Protocols, 14, e72631. https://doi.org/10.2196/72631

130. Washington State Health Care Authority. (2025). *Clubhouse and peer-run organizations: Fact sheet*. https://www.hca.wa.gov/assets/program/fact-sheet-clubhouse.pdf
131. WebstaurantStore. (2024). *What is a sober bar? Sober movements & popular drinks*. https://www.webstaurantstore.com/blog/4534/non-alcoholic-bars.html
132. Weir, K. (2025). 'Sober curiosity' destigmatizes the desire not to drink. *Monitor on Psychology, 56*(1). https://www.apa.org/monitor/2025/01/sober-curious-alcohol-moderation
133. White, W. (2000). *Toward a new recovery advocacy movement*. http://www.williamwhitepapers.com
134. White, W. L., Humphreys, K., Bourgeois, M., Chiapella, P., Evans, A., Flaherty, M., Gaumon, P., Haggerson, P., Haberle, B., Hill, T., Kaskutas, L. A., Kelly, J. F., McDaid, C., Powell, J., Scott, C., & Taylor, P. (2012). The status and future of addiction recovery support services in the United States: Betty Ford Institute consensus statement on recovery support services. *Public Health Reviews, 35*(2), 1–32.
135. White, W. L., Kelly, J. F., & Roth, J. D. (2012). New addiction-recovery support institutions: Mobilizing support beyond professional treatment and mutual-aid. *Journal of Groups in Addiction & Recovery, 7*(2–4), 297–317.
136. Williams, L., Armitage, C., Richardson, A., Davies, F., Smith, A., & Adnath, J. (2023). Service user experiences of participating in a recovery and collaborative care planning café framed with CHIME: A co-produced narrative paper. *Journal of Recovery in Mental Health, 6*(2), 90–96. https://doi.org/10.33137/jrmh.v6i2.39943
137. Zero-proof beverages and the sober curious movement. (2022). *Zero-proof beverages: A booming trend among the 'sober curious'*. *Today's Dietitian*.

Appendix: Psychometric Review – Validation Survey

Cynthia Beckworth, Ed.S. & Eric Martin, M.A., CADC-III, CRM-II, CPS

Participants scored 25 Best Practice descriptors developed by the SME Group based on the review of research and literature. Participants responded to a survey request emailed to peers employed at Recovery Community Centers in 48 U.S. States. 77 peers, nationwide, completed the survey.

Items were reviewed using Lawshe's Content Validity Ratio, standard Importance-Criticality Likert (1-5) scales and standard Clarity-Accuracy Likert (1-5) scales.

All items met accepted criteria for content inclusion and were validated. Six items scored lower on CVR, Criticality and/or Clarity and were referred to the SME facilitators for editing.

Best Practice Statement		Lawshe CVR 0-1	Important-Critical Likert 1-5	Clear-Accurate Likert 1-5
1	RCCs are Peer-Led with a Non-Clinical Identity	0.91	4.890625	4.625
2	**RCCs facilitate The Social Model of Recovery and Boundary Management**	0.97	4.846154	**4.507692**
3	**RCCs are capable of providing Co-occurring SUD & Mental Health Support**	0.94	4.815385	**4.523077**
4	RCCs operate within Recovery-Oriented Systems of Care (ROSC)	0.97	4.923077	4.753846
5	**RCCs operate Authentic Many Pathways Framework**	**0.84**	4.71875	4.671875
6	RCCs Facilitate Peer Leadership & Participatory Governance	0.93	4.846154	4.707692
7	**RCCs promote Radical Hospitality, Belonging & Inclusiveness**	**0.87**	4.707692	4.615385
8	RCCs provide Low-Barrier, Voluntary Access	0.90	4.769231	4.71875
9	**RCCs provide Safe, Predictable, Affirming, Home-Like, Trauma-Informed Environments**	**0.84**	4.661538	**4.538462**
10	RCCs implement Engagement Monitoring & Real-Time Responsiveness	1.00	4.953846	4.861538
11	RCCs build Recovery Capital	1.00	4.9375	4.876923
12	RCCs provide Peer Support	0.96	4.9375	4.78125
13	RCCs facilitate Social Identity & Belonging	0.96	4.846154	4.765625

14	RCCs incorporate Families and promote Parental Supports	0.96	4.876923	4.765625
15	RCCs integrate Risk Reduction & Health Promotion Principles	1.00	4.938462	4.815385
16	RCCs feature Employment as Central to Recovery	1.00	4.953125	4.830769
17	Leadership Development & Civic Engagement	0.87	4.769231	4.692308
18	**RCCs provide Developmentally Responsive Services Throughout the Adult Lifespan**	0.90	4.769231	**4.523077**
19	Crisis Recognition & De-Escalation	1.00	4.984375	4.875
20	Bridge & Transition Services	1.00	4.969231	4.8
21	Organizational Sustainability	0.96	4.892308	4.892308
22	Data-Informed Continuous Quality Improvement	1.00	4.938462	4.861538
23	Workforce Development & Supervision	0.93	4.861538	4.723077
24	Model Fidelity with Adaptive Innovation	0.96	4.953125	4.861538
25	RCCs & Specialty Populations	0.90	4.815385	4.830769

Summary of written feedback from survey participants:

1. Use inclusive, plain-language wording that reflects all recovery pathways, including active use, moderation, abstinence, and medication-assisted recovery.
2. Clarify that RCCs welcome people at any stage of substance use or recovery, with or without diagnosis or treatment readiness.
3. Reduce clinical jargon and simplify complex terms for broader community understanding.
4. Emphasize RCCs as safe, nonjudgmental spaces that build trust, belonging, recovery identity, and supportive social connection.
5. Highlight the role of peers as trusted role models, advocates, resource brokers, and connectors to community supports.
6. Include the importance of practical supports such as food, employment connections, resource mapping, and addressing service gaps.
7. Acknowledge collaboration with community partners, hospitals, volunteers, participants, and the peer workforce as essential.
8. Add attention to staff culture, communication, consistency, burnout prevention, and limited staffing capacity.
9. Clarify whether RCC services are intended for adults, youth, or mixed-age settings.
10. Consider adding the science behind pro-social activities, community connection, and ecotherapy as supports for healing and belonging.