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Community Rounds
WORKSHOP SERIES

September 8, 2021

Peer Recovery as an Evidence-Based Practice: From Science to Impact

John Kelly, PhD, ABPP

Mark Depman, MD

Liza Ryan, Peer Recovery Specialist

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This presentation is part of the Community Rounds Workshop Series

These sessions are provided monthly thanks to the University of Vermont Center on Rural Addiction, the Vermont Center on Behavior and Health, and a grant from the Health Services and Resources Administration.

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Outline: Peer Recovery as an Evidence-Based Practice: From Science to Impact

11:00-11:30		John F. Kelly, PhD, Recovery Research Institute **One-Stop Shopping for Recovery: Rationale and Research on Peer Recovery Community Centers**
11:30-12:00		Mark Depman, MD, Central Vermont Medical Center **Assertively Linking People to Care: Building a Peer Recovery Coach Program in the Emergency Department**
12:00-12:30		Liza Ryan, BSW, North Central Vermont Recovery Center **Peer Recovery Coaching: The Impact**
12:30-1:00		All Presenters **Question and Answer**

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Session Objectives

- Discuss evidence surrounding peer recovery models
- Describe how peer recovery has evolved over the past 20 years
- Challenges and opportunities for implementing peer recovery models in a rural ED
- Describe the benefit peer recovery coaches provide people with SUD, including peer recovery centers, EDs, and MAT clinics
- Explain the significance of rurality on peer recovery

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Continuing Education Credits

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Disclosures

There is nothing to disclose for this UVM CORA Community Rounds session.

Potential Conflict of Interest (*if applicable*):

All Potential Conflicts of Interest have been resolved prior to the start of this program.

All recommendations involving clinical medicine made during this talk were based on evidence that is accepted within the profession of medicine as adequate justification for their indications and contraindications in the care of patients.

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RECOVERY RESEARCH INSTITUTE
MASSACHUSETTS GENERAL HOSPITAL
HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

One-Stop Shopping for Recovery: Rationale and Research on Peer Recovery Community Centers

Name, Credentials (ex: MD, PhD, etc)

Faculty/Staff position (ex: Associate Professor, Maternal Fetal Medicine, University of Vermont, Burlington, VT)

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Outline

- What are Peer Recovery Community Centers?
- Why did they emerge and grow?
- How might they work?
- What do we know about their impact?

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Recovery Community Centers are intended to …

- Provide locatable sources of community-based recovery peer to peer support beyond the clinical setting…
- Help individuals achieve sustained recovery by building and successfully mobilizing personal, social, environmental, and cultural resources (recovery capital)

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Recovery Community Centers are NOT…

Residential centers

Sober living environments

Treatment centers

12-step clubhouses

Drop-in (clinical) centers

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Principles of RCCs

Source of recovery capital at the community level

- Provide different services than formal treatment
- Offer more formal and tangible linkages to social services, employment, training and educational agencies than do mutual-help organizations

There are many pathways to recovery

- RCCs not allied with any specific recovery philosophy/model
- All and any pathway to recovery should be celebrated

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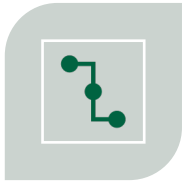
RCCs may foster or provide many of the active ingredients of recovery reported by persons in recovery…(CHIME)



CONNECTION

HOPE AND OPTIMISM

POSITIVE SOCIAL IDENTITY

MEANING AND PURPOSE

EMPOWERMENT

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Challenges faced by rural Peer Recovery Community Centers include…

Transportation

Workforce and service availability

Privacy

Peer support network

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Rural RCCs and Transportation

- Longer travel duration
- Limited access to public transportation
- Financial burden of public and private transportation
- Higher change of transportation accidents

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Rural RCCs, Workforce, and Services

- Lower quorum of people in recovery means fewer people able to run centers and programs
- Fewer recoverees/staff may reduce “sense of community”
- Limited funding depending on RCC’s funding source
- Certain services may not be offered, or are offered in lower quantity/quality
- Limited Internet access or low quality Internet

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Privacy

- Smaller communities afford less anonymity
- Social stigma of substance use disorder (even in recovery)

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Rural RCCs and Peer Support Networks

- Smaller recovery community
- Group meetings and other community events will be smaller and may not meet a sufficient threshold of peer support needed to facilitate therapeutic factors
- Subgroups within the recovery population (e.g., veterans, racial/ethnic minority groups, LGBTQ+) may not have access to peers or services that meet needs of subgroups offered by urban RCCs
- People may have to travel long distances to enter treatment programs and become isolated from their local peer RCC community

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Outline

- What are Recovery Community Centers?
- Why did they emerge and grow?
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- What do we know about their impact?

Clinical course to remission for addiction cases… can we speed this up?

Opportunity for earlier detection through screening in non-specialty settings like primary care/ED

Self-initiated cessation attempts

4-5 Treatment episodes/ mutual-help

Continuing care/ mutual-help

Recovery Priming

Recovery Mentoring

Recovery Monitoring

75% of individuals with SUD will achieve full sustained remission

50 years of Progress: Burning building analogy…

- **Putting out the fire** –addressing acute clinical pathology - good job
- **Preventing it from re-igniting** (RP) - strong emphasis, but pragmatic disconnect…
- **Architectural planning** (recovery plan) –neglected
- **Building materials (recovery capital) –**neglected
- **Granting "rebuilding permits"** - (removing barriers - neglected)

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In fact, the concept of SUD "treatment" is changing…

The best treatment programs provide a combination of therapies and other services to meet the needs of the individual patient.

NIH National Institute on Drug Abuse
The Science of Drug Abuse & Addiction

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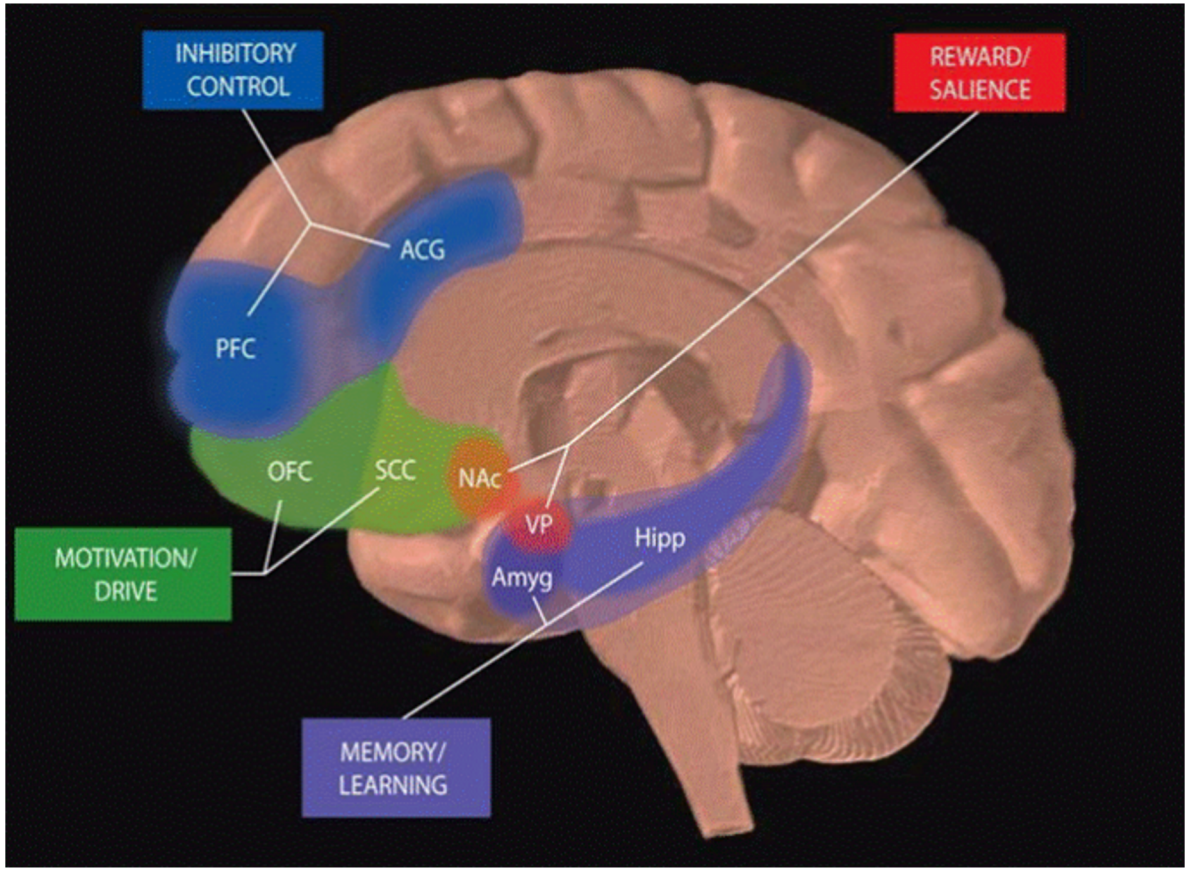
Circuits Involved in Drug Use and Addiction



All of these brain regions must be considered in developing strategies to effectively treat addiction.

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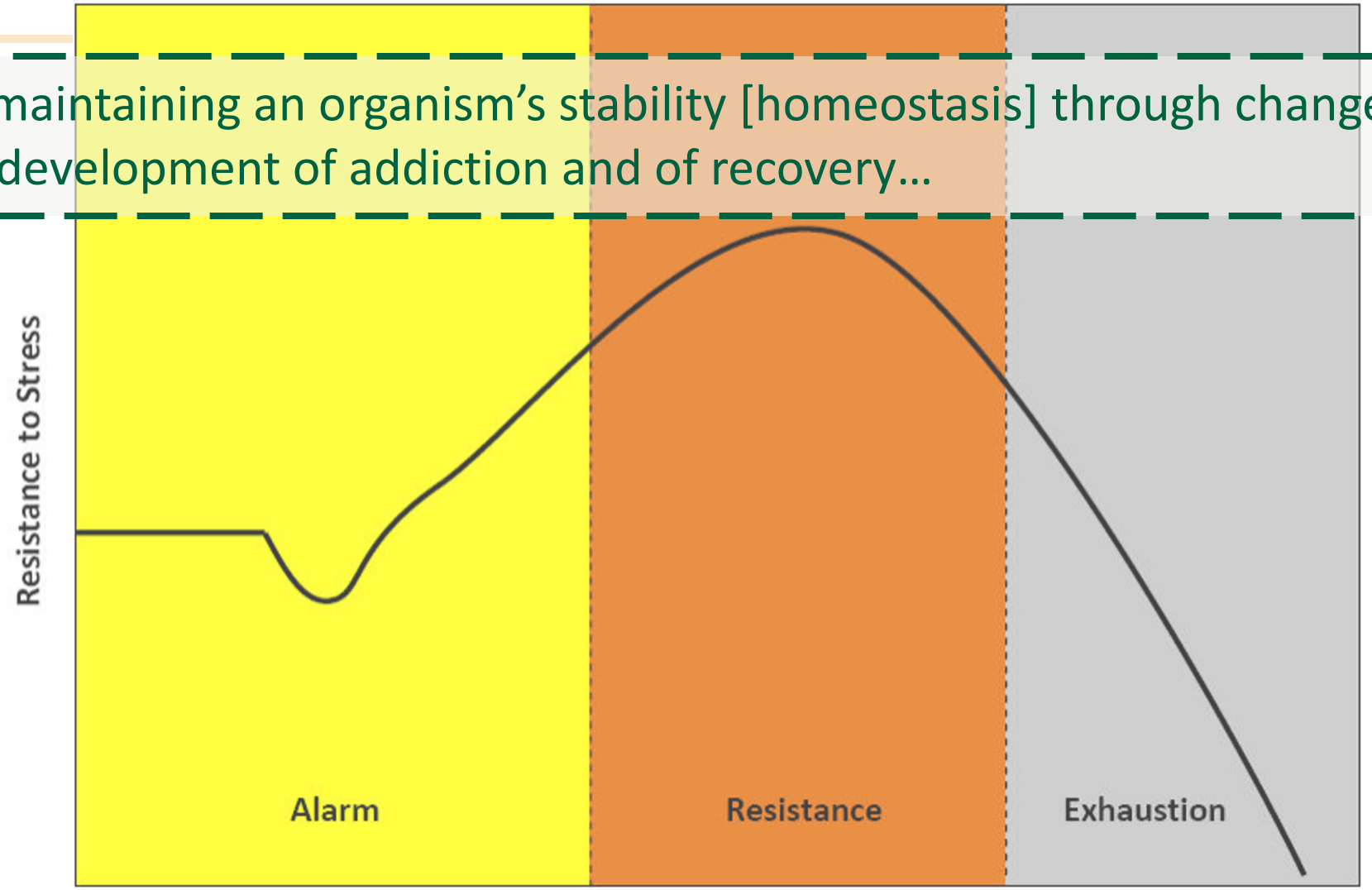
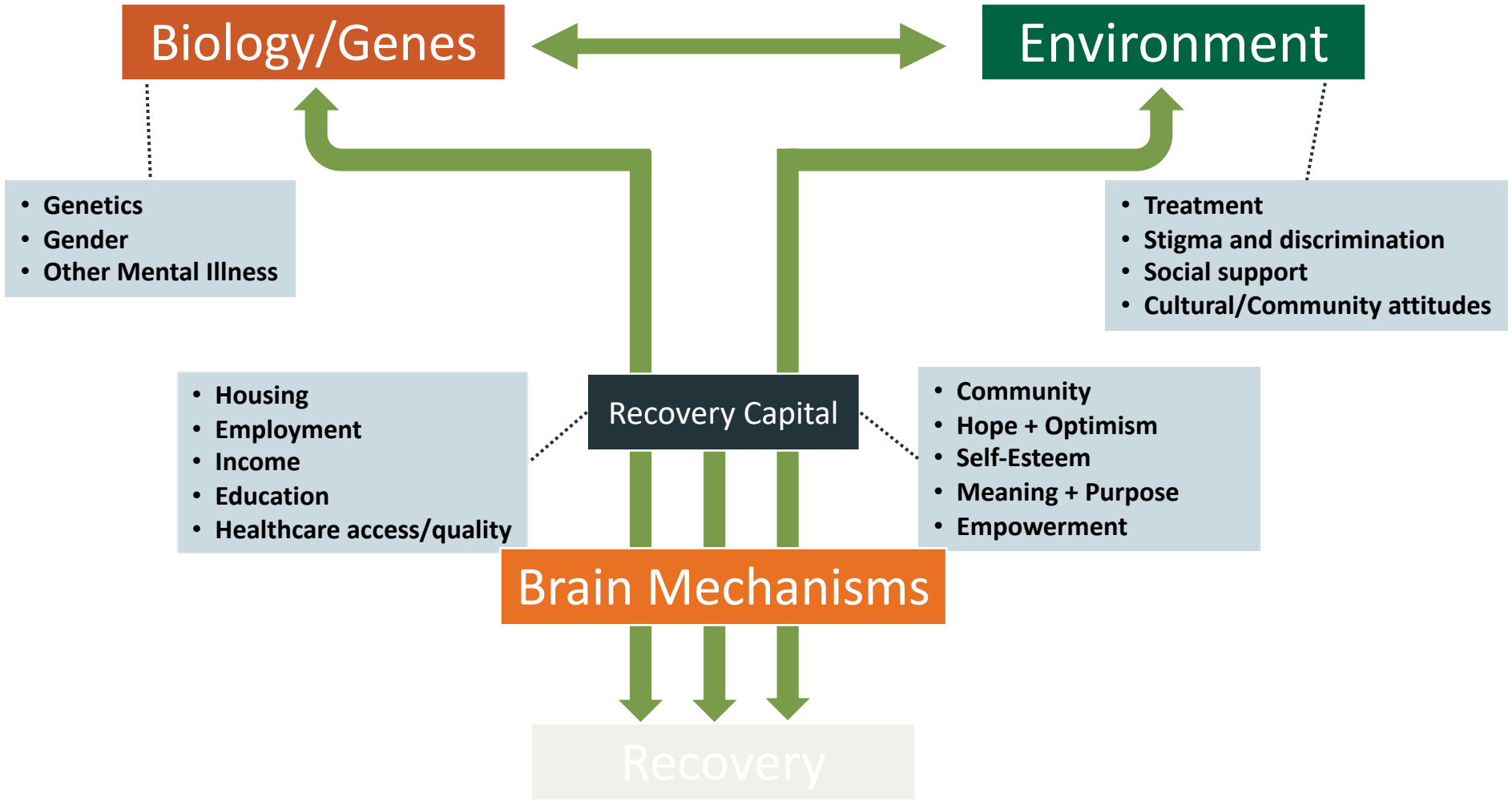
Allostasis (maintaining an organism's stability [homeostasis] through change) occurs both during the development of addiction and of recovery…



RECOVERY IS A COMPLEX PROCESS

RESILIENCE FACTORS



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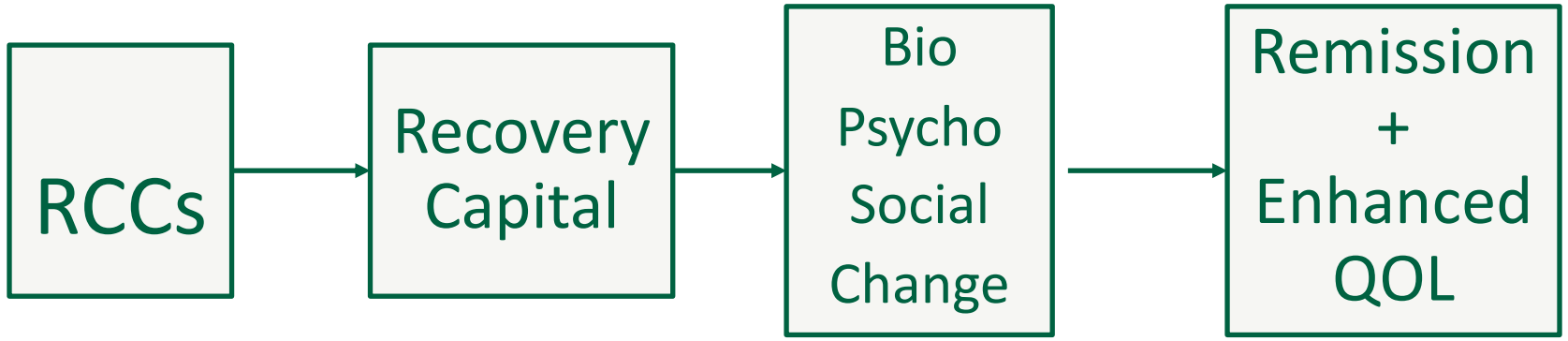
RCCs Mechanisms



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Recovery Community Centers:

New Findings

Three aims…

- Survey of RCC directors and staff
- Cross-sectional survey of existing RCC participants
- Longitudinal investigation of new RCC participants

RCC Questions we need to answer…

- What are they?
- Where are they?
- Who runs them?
- Who uses them?
- How are they funded?
- What do they provide?
- How helpful are they?

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Investigation of RCCs:

Directors and Staff Interviews

Journal of Substance Abuse Treatment 111 (2020) 1–10

Contents lists available at ScienceDirect

Journal of Substance Abuse Treatment

journal homepage: www.elsevier.com/locate/jsat

New kid on the block: An investigation of the physical, operational, personnel, and service characteristics of recovery community centers in the United States

John F. Kelly[a,*], Nilofar Fallah-Sohy[a], Corrie Vilsaint[a], Lauren A. Hoffman[a], Leonard A. Jason[b], Robert L. Stout[c], Julie V. Cristello[a], Bettina B. Hoeppner[a]

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ARTICLE INFO

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Recovery coaching
Addiction
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ABSTRACT

Background: Professional treatment and non-professional mutual-help organizations (MHOs) play important roles in mitigating addiction relapse risk. More recently, a third tier of recovery support services has emerged that are neither treatment nor MHO that encompass an all-inclusive flexible approach combining professionals and volunteers. The most prominent of these is Recovery Community Centers (RCCs). RCC's goal is to provide an attractive central recovery hub facilitating the accrual of recovery capital by providing a variety of services (e.g., recovery coaching; medication assisted treatment [MAT] support, employment/educational linkages). Despite their growth, little is known formally about their structure and function. Greater knowledge would inform the field about their potential clinical and public health utility.

Method: On-site visits (2015–2016) to RCCs across the northeastern U.S. (K = 32) with semi-structured interviews conducted with RCC directors and online surveys with staff assessing RCCs': physicality and locality; operations and budgets; leadership and staffing; membership; and services.

Results: Physicality and locality: RCCs were mostly in urban/suburban locations (90%) with very good to excellent Walk Scores reflecting easy accessibility. Ratings of environmental quality indicated neighborhood/grounds/buildings were moderate-good attractiveness and quality. *Operations*: RCCs had been operating for an average of 8.5 years (SD = 6.2; range 1–33 years) with budgets (mostly state-funded) ranging from $17,000–$760,000/year, serving anywhere from a dozen to more than two thousand visitors/month. *Leadership and staffing*: Center directors were mostly female (55%) with primary drug histories of alcohol (62%), cocaine (19%), or opioids (19%). Most, but not all, directors (90%) and staff (84%) were in recovery. *Membership:* A large proportion of RCC visitors were male (61%), White (72%), unemployed (50%), criminal-justice system-involved (43%) and reported opioids (35%) or alcohol (33%) as their primary substance. Roughly half were in their first year of recovery (49%), but about 20% had five or more years. *Services*: RCCs reported a range of services including social/recreational (100%), mutual-help (91%), recovery coaching (77%), and employment (83%) and education (63%) assistance. Medication-assisted treatment (MAT) support (43%) and overdose reversal training (57%) were less frequently offered, despite being rated as highly important by staff.

Conclusions: RCCs are easily accessible, attractive, mostly state-funded, recovery support hubs providing an array of services to individuals in various recovery stages. They appear to play a valued role in facilitating the accrual of social, employment, housing, and other recovery capital. Research is needed to understand the relative lack of opioid-specific support and to determine their broader impact in initiating and sustaining remission and cost-effectiveness.

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RESULTS

'New Kid On The Block'

- Mostly in urban/suburban locations, have moderate-good attractiveness/ quality and are fairly quickly accessible

- Operating for an average of **8.5 years** with a dozen to more than two thousand visitors/month

- Center directors were mostly **female** with primary drug histories of alcohol , cocaine, or opioids.
    - Most, but not all, directors and staff were in recovery.

- RCC **visitors:** Male, White, unemployed, criminal-justice system-involved

- RCCs reported a **range of services** including
    - Social/Recreational
    - Mutual-Help
    - Recovery Coaching
    - Employment and Education Assistance
    - Medication-assisted treatment (MAT) support and overdose reversal training were less frequently offered, despite their high ratings by staff

Kelly JF et al. New Kid on the Block: An Investigation of the Physical, Operational, Personnel and Service Characteristics of Recovery Community Centers in The United States

RESULTS: Referral Source

'New Kid On The Block'

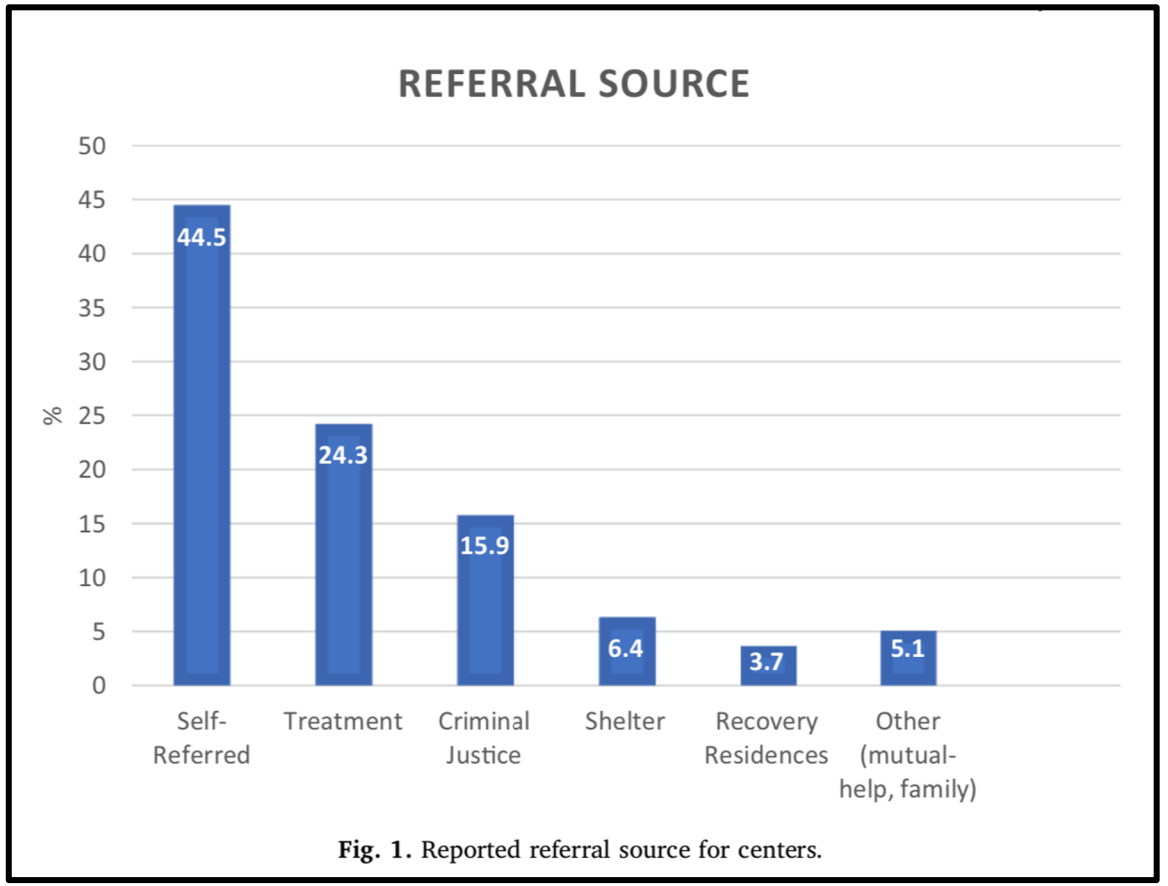
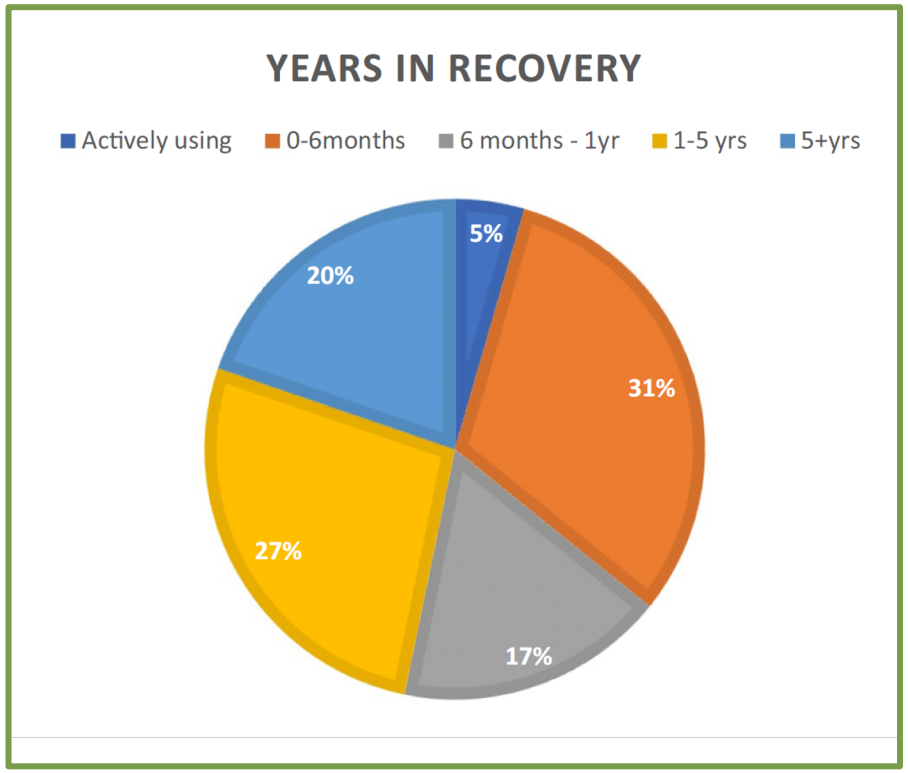
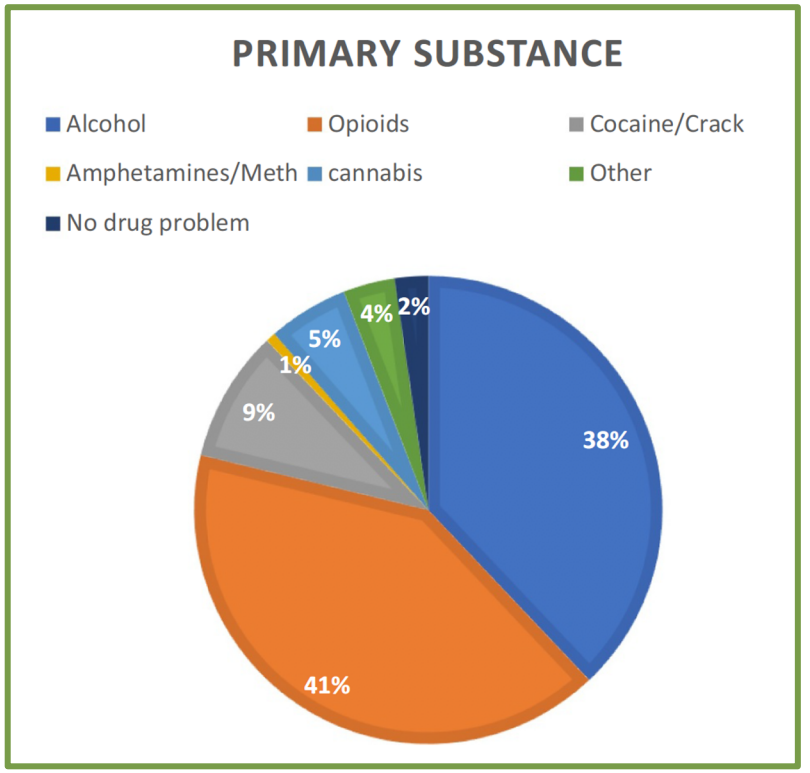


Fig. 1. Reported referral source for centers.

RESULTS

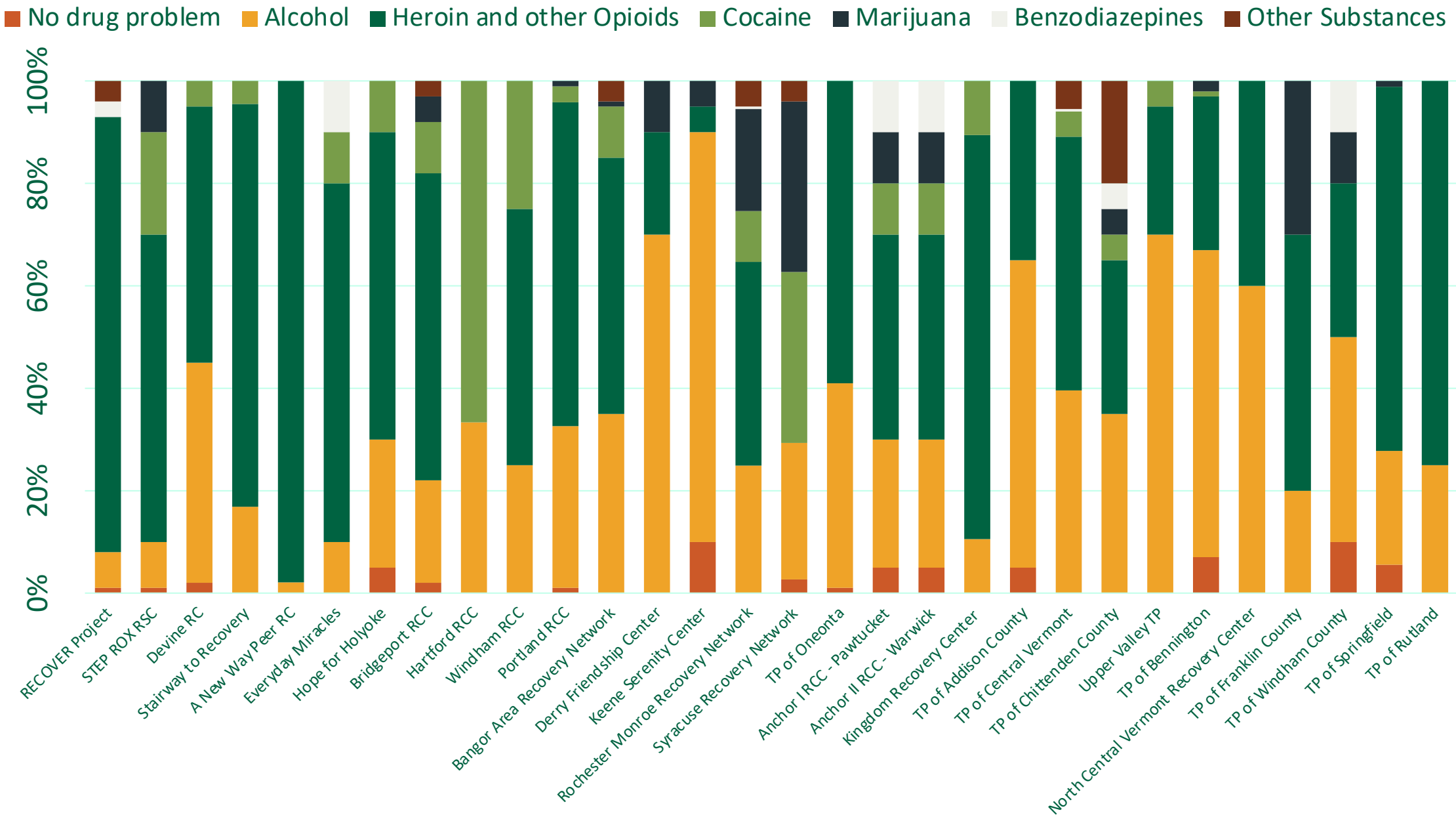
'New Kid On The Block'





Kelly JF et al. New Kid on the Block: An Investigation of the Physical, Operational, Personnel and Service Characteristics of Recovery Community Centers in The United States

Primary Substance by Center



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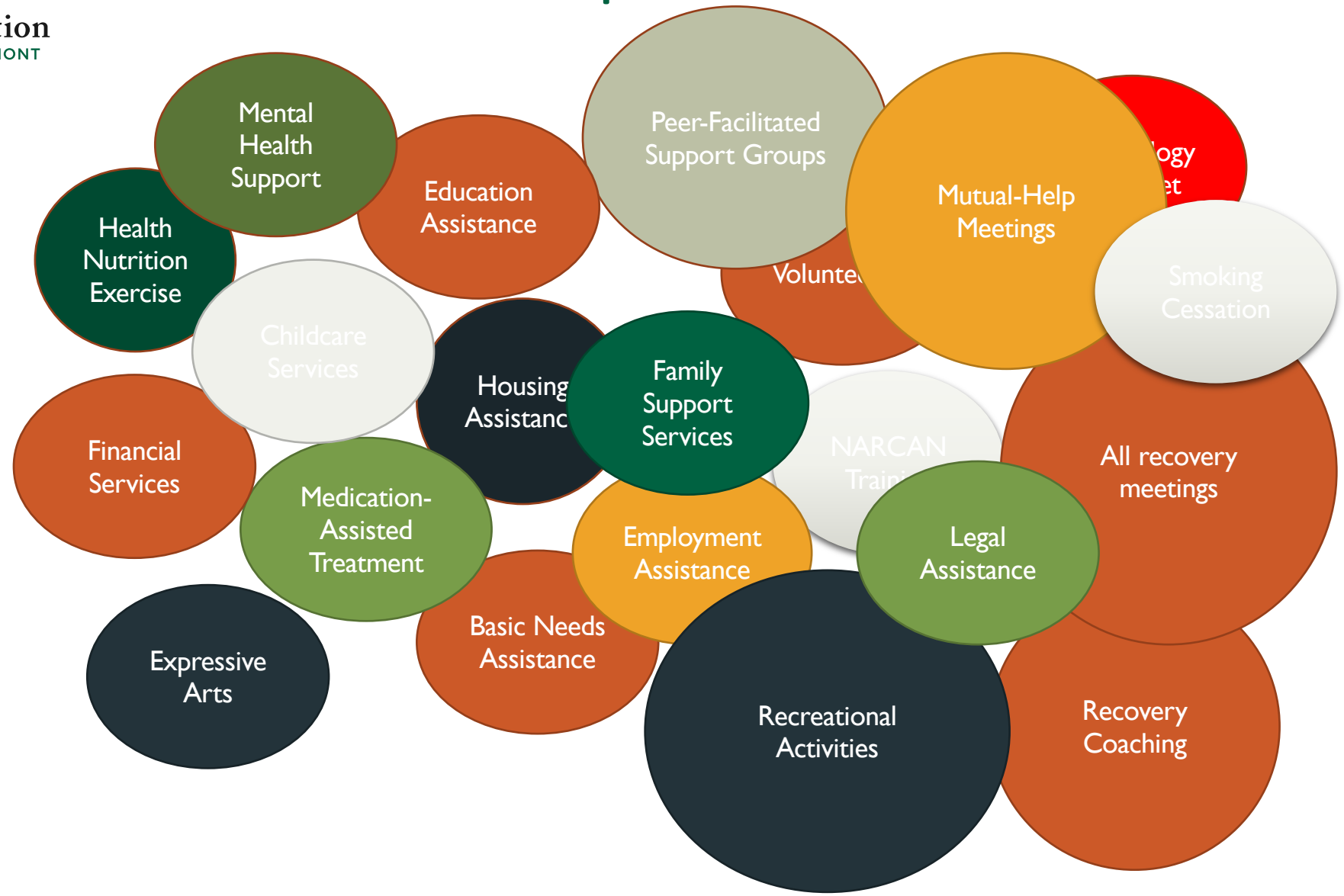
Services provided



Services Provided

Services offered by RCCs and their perceived importance rated by RCC staff.

Service	% offered (30 centers)[a]		Perceived importance[b] (55 staff)	
	%	(n)	Mean	(*SD*)
Support group meetings				
"All recovery" meetings	60.0	(18)	6.3	(1.3)
Mutual-help groups by known organizations (e.g., Alcoholics Anonymous)	96.7	(29)	6.6	(0.7)
Other peer-facilitated recovery support groups (e.g., relapse prevention groups)	76.7	(23)	6.6	(0.7)
Mental health support (e.g., dual diagnosis support groups)	36.7	(11)	6.1	(1.0)
Recovery coaching (and/or case management)	76.7	(23)	6.2	(1.4)
Opioid and/or harm reduction services				
Medication-assisted treatment (MAT) support (e.g., Pathway Guide, MARS group)	43.3	(13)	5.9	(1.6)
NARCAN training and/or distribution	56.7	(17)	6.3	(1.2)
Provision of access to technology/internet (e.g., use of center computers, printers, fax)	46.7	(14)	5.6	(1.4)
Assistance with basic needs and social services				
Basic needs assistance (e.g., access to food, clothing, transportation)	43.3	(13)	5.8	(1.2)
Childcare services	10.0	(3)	4.8	(1.6)
Education assistance	63.3	(19)	5.6	(1.3)
Employment assistance (e.g., job or computer skills, resume writing, CORI support)	83.3	(25)	5.9	(1.2)
Family support services (e.g., family/parent education or support groups)	86.7	(26)	6.1	(1.1)
Financial services	23.3	(7)	5.1	(1.6)
Health insurance education	36.7	(11)	5.2	(1.4)
Housing assistance	70.0	(21)	5.9	(1.3)
Legal assistance	16.7	(5)	5.0	(1.8)
Assistance with health behaviors				
Health, exercise, and nutrition programs (e.g., yoga, meditation, fitness classes)	83.3	(25)	5.7	(1.3)
Smoking cessation support	53.3	(16)	5.0	(1.7)
Facilitation of substance-free recreational activities				
Recreational/social activities (e.g., substance free social events)	100.0	(30)	6.3	(1.0)
Expressive arts (e.g., arts/craft groups, music, poetry)	53.3	(16)	5.4	(1.3)

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Cross-Sectional Analysis

Existing RCC Participants

ALCOHOLISM: CLINICAL AND EXPERIMENTAL RESEARCH

Vol. 44, No. 3
711-721

One-Stop Shopping for Recovery: An Investigation of Participant Characteristics and Benefits Derived From U.S. Recovery Community Centers

John F. Kelly, Robert L. Stout, Leonard A. Jason, Nilofar Fallah-Sohy, Lauren A. Hoffman, and Bettina B. Hoeppner

Background: Recovery community centers (RCCs) are the "new kid on the block" in providing addiction recovery services, adding a third tier to the 2 existing tiers of formal treatment and mutual-help organizations (MHOs). RCCs are intended to be recovery hubs facilitating "one-stop shopping" in the accrual of recovery capital (e.g., recovery coaching; employment/educational linkages). Despite their growth, little is known about who uses RCCs, what they use, and how use relates to improvements in functioning and quality of life. Greater knowledge would inform the field about RCC's potential clinical and public health utility.

Methods: Online survey conducted with participants (N = 336) attending RCCs (k = 31) in the northeastern United States. Substance use history, services used, and derived benefits (e.g., quality of life) were assessed. Systematic regression modeling tested a priori theorized relationships among variables.

Results: RCC members (n = 336) were on average 41.1 ± 12.4 years of age, 50% female, predominantly White (78.6%), with high school or lower education (48.8%), and limited income (45.2% < $10,000 past-year household income). Most had either a primary opioid (32.7%) or alcohol (26.8%) problem. Just under half (48.5%) reported a lifetime psychiatric diagnosis. Participants had been attending RCCs for 2.6 ± 3.4 years, with many attending <1 year (35.4%). Most commonly used aspects were the socially oriented mutual-help/peer groups and volunteering, but technological assistance and employment assistance were also common. Conceptual model testing found RCCs associated with increased recovery capital, but not social support; both of these theorized proximal outcomes, however, were related to improvements in psychological distress, self-esteem, and quality of life.

Conclusions: RCCs are utilized by an array of individuals with few resources and primary opioid or alcohol histories. Whereas strong social supportive elements were common and highly rated, RCCs appear to play a more unique role not provided either by formal treatment or by MHOs in facilitating the acquisition of recovery capital and thereby enhancing functioning and quality of life.

Key Words: Recovery Community Centers, Recovery, Addiction, Support Services, Recovery Coaching, Addiction, Substance Use Disorder.

PROFESSIONAL TREATMENT SERVICES often play a vital role in addressing substance use disorders in the United States and around the world. Such clinical services can provide life-saving medically managed detoxification and stabilization as well as deliver medications and psychosocial interventions that can alleviate cravings and help prevent relapse. Extending the framework and benefits of these professional treatment efforts, peer-led mutual-help organizations (MHOs), such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), SMART Recovery, and many others are commonly used to provide additional long-term free recovery support over time in the communities in which people live (Bøg et al., 2017; Kelly, 2017; Kelly et al., 2017a). Adding to these resources in recent years has been a new dimension of recovery support services that are neither professional treatment nor MHOs. These new services (e.g., recovery community centers [RCCs], recovery residences, recovery coaching, recovery high schools, and collegiate recovery programs; Kelly et al., in press; White et al., 2012, 2012) combine voluntary, peer-led initiatives, with professional activities, and are intended to provide flexible community-based options to address the psychosocial barriers to sustained remission (White et al., 2012, 2012).

RCCs are one of the most common of these new additions to recovery support infrastructure and are growing rapidly (Cousins et al., 2012; Kelly et al., in press; Kelly et al., 2017b). RCCs are literally and metaphorically, "new kids on the block," as these novel entities are most often located on

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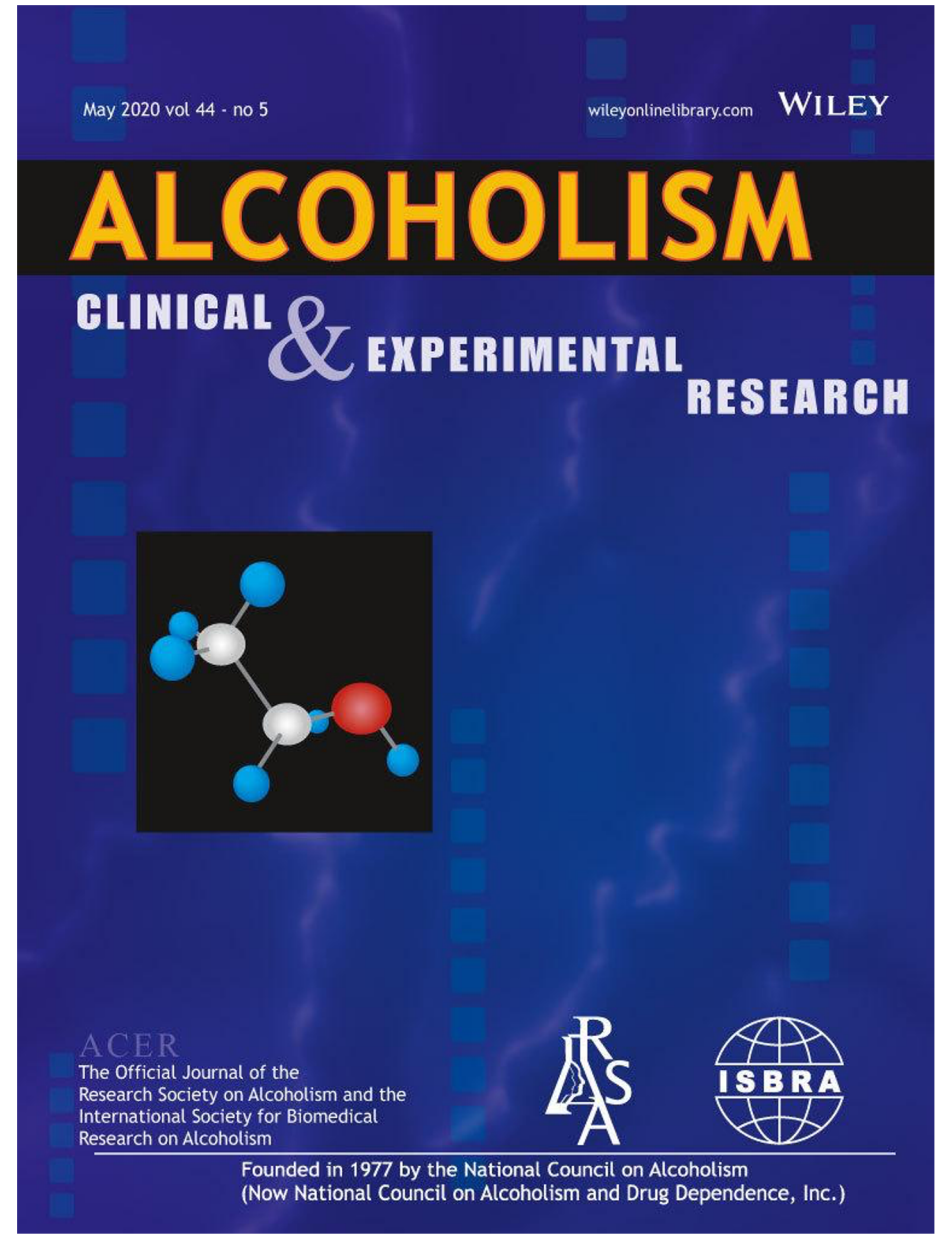

Cross-Sectional Results of Current RCC members (N=336)

- **Age/gender**: Mean age = 41 (SD 12.4); 50% women
- **Sexual Minority Status**: 23% LGBTQ
- **Race/Ethnicity**: Predominantly White (78.6%); 11% Hispanic
- **Education:** high school or lower education (48.8%)
- **Income**: 45.2% <$10,000 past-year household income
- **Primary Substance**: Most had either primary opioid (32.7%) or alcohol (26.8%); also some cocaine (13.7%)
- **Psychiatric Diagnosis** (Lifetime): Just under half (48.5%)
- **Prior SUD treatment**: 72%

Cross-Sectional Survey (N=366) - RCC Experiences

	Total	
	Mean/%	(SD/*n*)
RCC experience		
Referral source		
Family and friends	44.0	(148)
SUD treatment (detox, inpatient, outpatient)	14.6	(49)
Housing and social services (e.g., sober living, shelter, including DSS)	13.7	(46)
RCC outreach (e.g., street outreach, Internet, pamphlets, community event, and ads)	11.6	(39)
Health care (PCP, ED)	5.4	(18)
Other (e.g., employer, 12-step, church, and academic)	8.9	(30)
Length of RCC attendance (in years)	2.6	(3.4)
Less than a year	35.4	(119)
1 to 5 years	49.1	(165)
5+ years	14.0	(47)
Percent days attended RCC in past 90 days (in mean, SD)	45.5	(32.1)
Length of typical RCC visit (in hours)	3.1	(2.7)
RCC appraisal		
RCC's helpfulness to recovery	6.2	(1.2)
RCC's helpfulness to QOL	6.1	(1.2)
RCC's sense of community (in mean, SD)		
Self (identity and importance to self)	5.3	(1.0)
Membership (social relationships)	5.2	(1.0)
Entity (a group's organization and purpose)	5.3	(1.0)
Recovery assets		
Recovery capital (BARC; 10 items, 1- to 6-point scale)	5.0	(0.9)
Social support for recovery (CEST-SS; 9 items, 1- to 6-point scale)	4.8	(1.0)
Quality of life (QOL) (in mean, SD)		
Quality of Life (EUROHIS-QOL; 8 items, 1- to 5-point scale)	3.8	(0.7)
Self-esteem (1 item, 1- to 10-point scale)	6.5	(2.3)
Psychological distress (Kessler-6, 6 items, 0- to 4-point scale)	2.0	(0.8)

Of note, QOL in this sample was half a SD higher than in NRS study despite shorter time in recovery in this sample….

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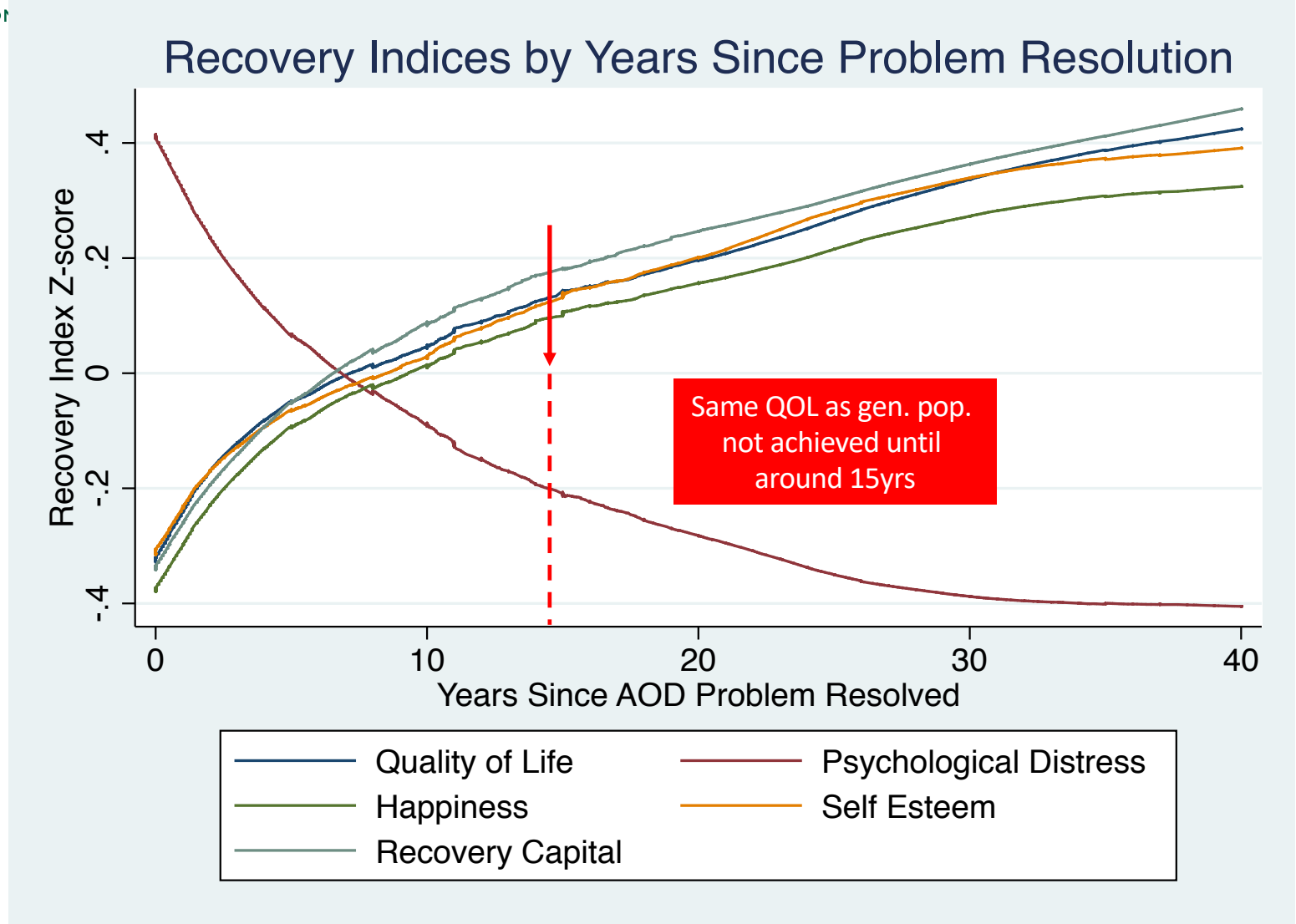


Kelly et al (2018) *Alcoholism: Clinical and Experimental Research*

RESULTS

'One-Stop Shopping For Recovery'

Table 2. RCC Services Used and Their Perceived Helpfulness

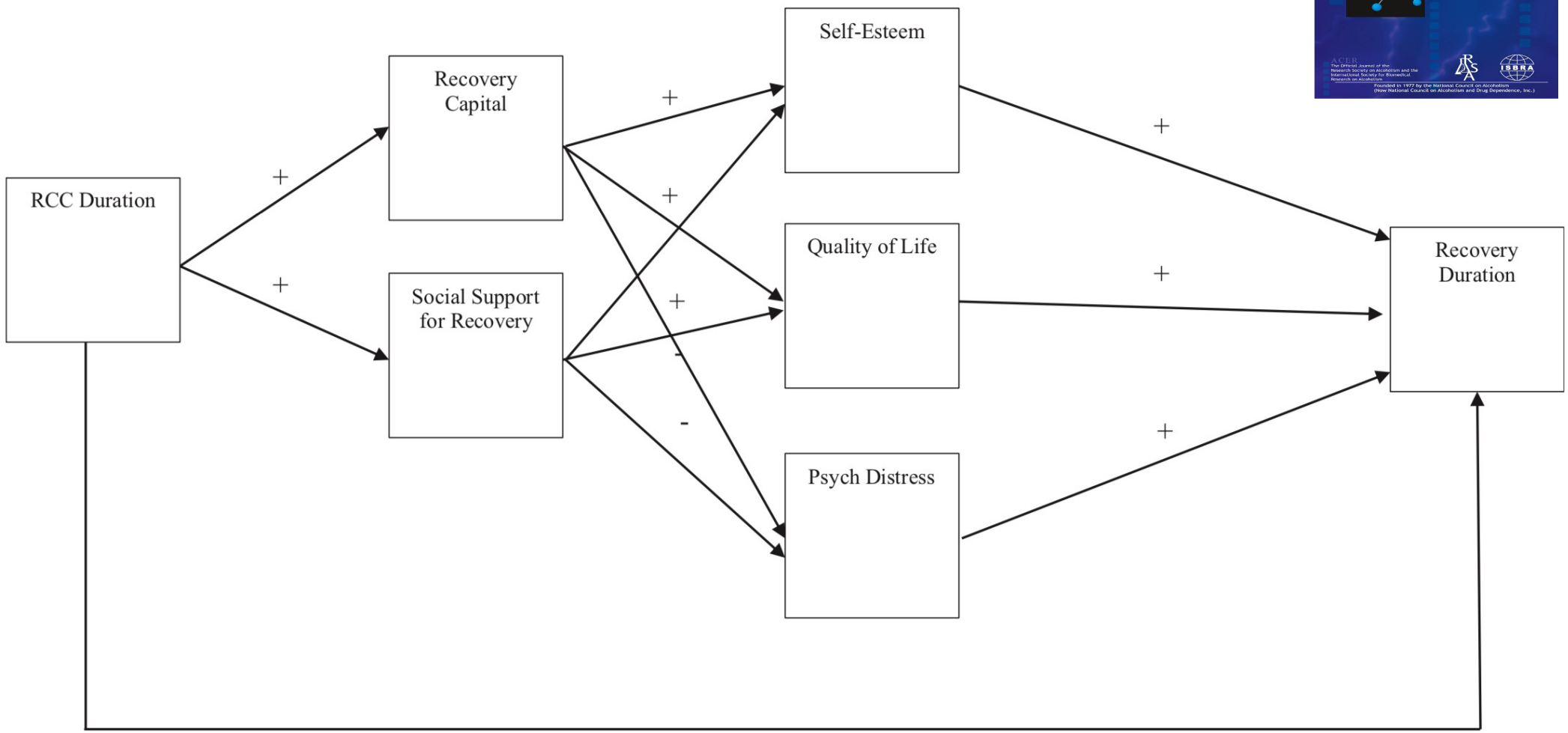
RCC service	Used service %	Used service (*n*)	Rated helpfulness Mean	Rated helpfulness (SD)
All recovery meetings	64.9	(218)	6.1	(1.2)
Mutual-help groups	58.6	(197)	6.1	(1.3)
Peer-facilitated recovery support groups	54.2	(182)	6.1	(1.2)
Opportunity to volunteer/give back to the center	44.3	(149)	6.6	(0.8)
Recreational/social activities	40.8	(137)	6.2	(1.1)
Recovery coaching	37.8	(127)	6.3	(1.2)
Technology/Internet access	27.1	(91)	6.5	(0.9)
Employment assistance	26.5	(89)	5.9	(1.5)
Recovery advocacy outreach and opportunities	24.1	(81)	6.5	(0.9)
NARCAN training and/or distribution	21.1	(71)	6.4	(1.0)
Health, exercise, and nutrition programs	17.0	(57)	6.1	(1.1)
Basic needs assistance	16.4	(55)	6.4	(1.2)
Housing assistance	15.2	(51)	5.8	(1.4)
Medication-assisted treatment	14.9	(50)	5.3	(1.4)
Expressive arts	14.9	(50)	6.2	(1.1)
Education assistance	13.1	(44)	5.8	(1.4)
Mental health support	12.8	(43)	5.9	(1.4)
Family support services	8.0	(27)	6.4	(1.1)
Smoking cessation support	7.7	(26)	5.7	(1.7)
Legal assistance	7.4	(25)	5.6	(1.8)
Health insurance education	5.7	(19)	5.4	(1.5)
Financial services	3.9	(13)	5.2	(2.0)
Childcare services	0.9	(3)	7.0	(0.0)

Helpfulness rated on a 1- to 7-point scale, where 1 = "Not at All Helpful" and 7 = "Extremely Helpful"; only participants who indicated using a service were asked to rate it.

Most commonly used services at RCCs

Rated Helpfulness of Services Used by Members

RCCs are utilized by an array of individuals with few resources and primary opioid or alcohol histories.



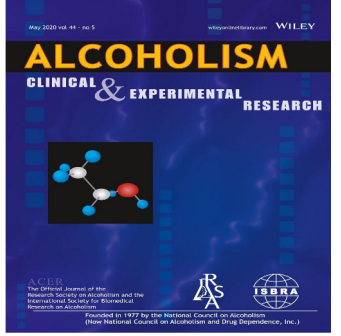


Fig. 1. Conceptual model of the theorized relationships among RCC duration and length of recovery with anticipated intermediate variables. Note: "+" = theorized positive association among linked variables; "−" = theorized negative association among linked variables.

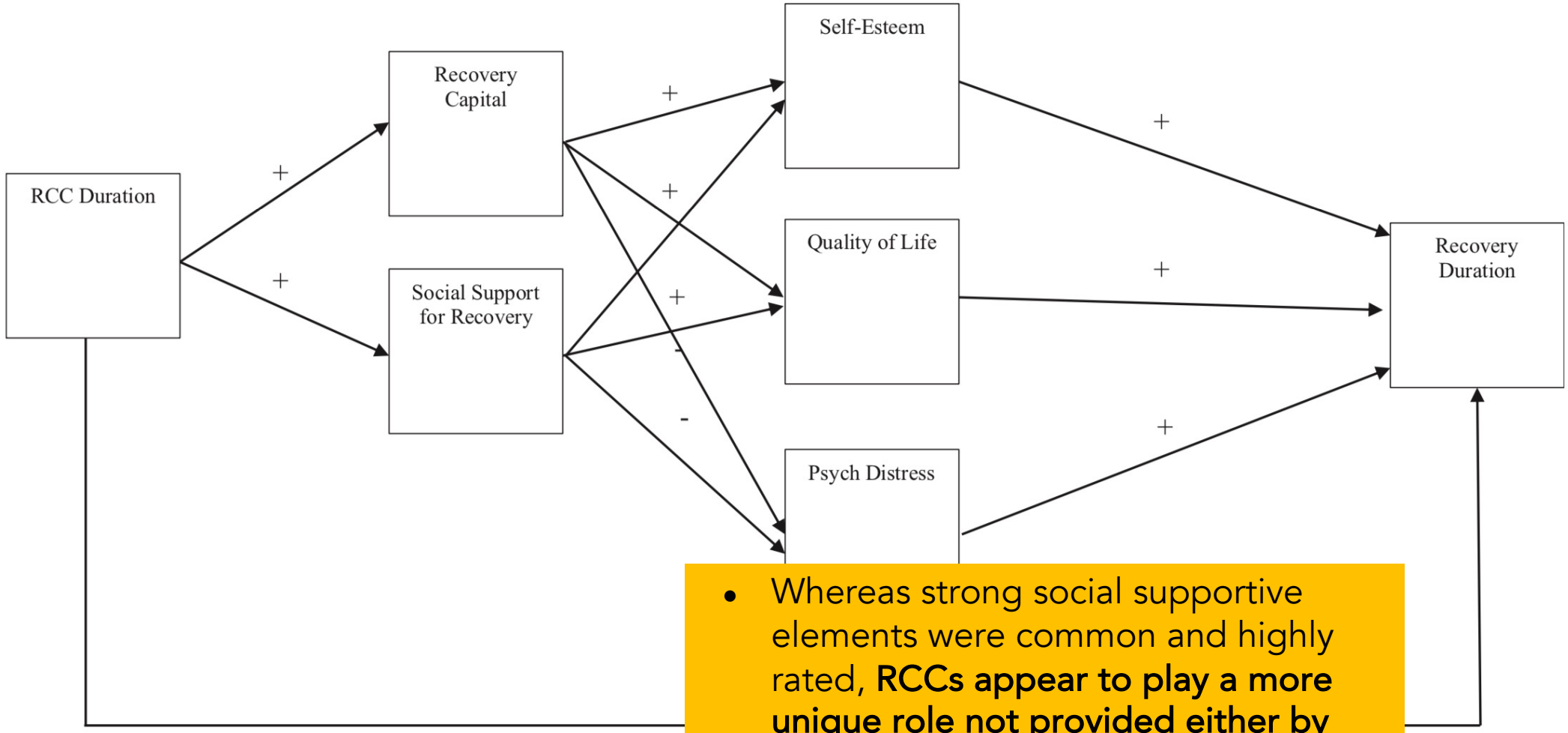


Fig. 1. Conceptual model of the theorized relationships among … diate variables. Note: "+" = theorized positive association among linked variables; "–" = …

- Whereas strong social supportive elements were common and highly rated, **RCCs appear to play a more unique role not provided either by formal treatment or by MHOs** in facilitating the acquisition of recovery capital and thereby enhancing functioning and quality of life.

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Longitudinal Analysis

New RCC Participants

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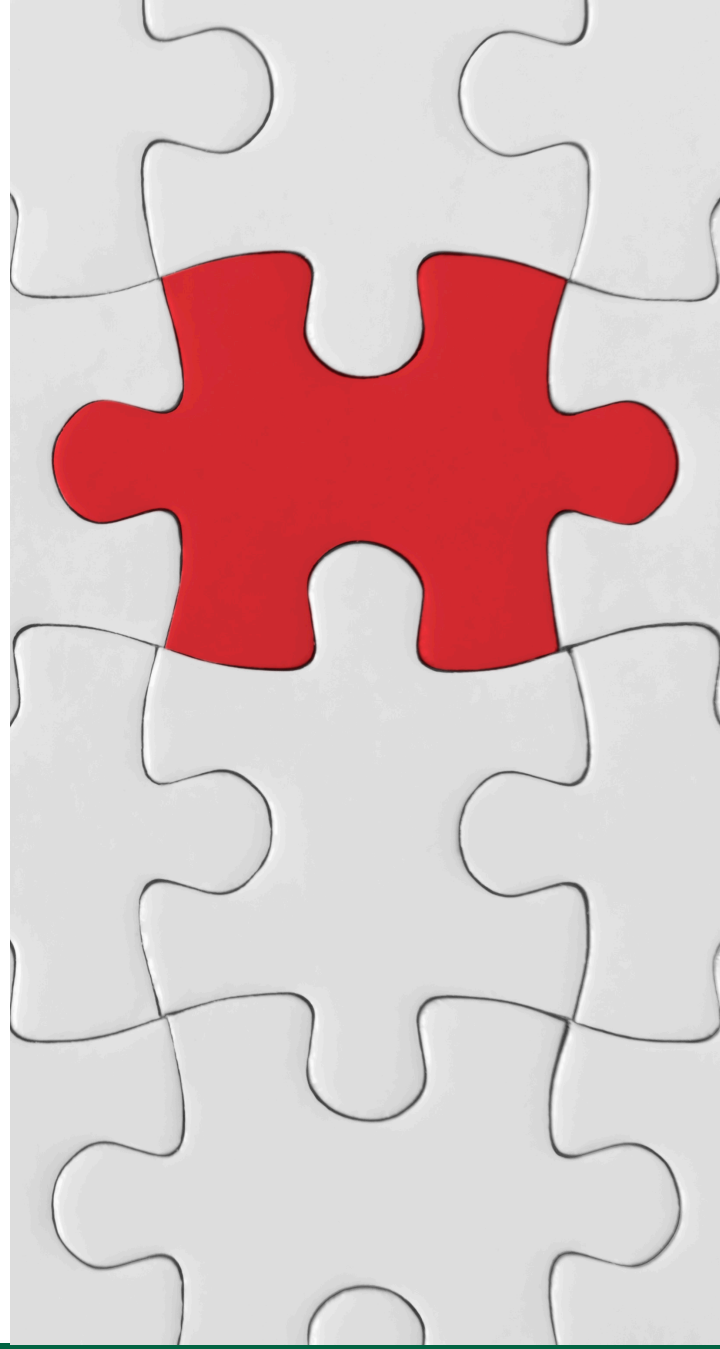
Results: Longitudinal Analysis of New Participants

- **New RCC participants** were either **in or seeking** recovery and were:
  - Mostly young- to middle-aged
  - Racially diverse
  - Single
  - Unemployed
  - Adult men and women
  - With low education and income
  - Suffering from primary opioid or alcohol use disorder
  - History of comorbid mental health problems
  - Prior professional and mutual-help organization participation.
- Reflects high clinical severity and few resources - indicative of a need to provide the kinds of recovery-specific support and infrastructures that RCCs are shown to possess (Haberle et al., 2014; Kelly, Fallah-Sohy, et al., 2020; Valentine, 2011).



PREDICTORS OF RCC ENGAGEMENT

Among new RCC attendees, sig. predictors of engagement were: how accessible the RCC was (**in travel time – implications for rural areas**); higher QOL (but was 1 SD lower than gen. pop; Hispanic ethnicity; prior outpt tx

Approx. 60% FOLLOWED UP

Table 2 - Predictors of RCC Engagement (n=275 included, n=138 with known outcome)

Type of Variable	Univariate				Multivariable [b]			
Variable	OR	95% CI		p	aOR	95% CI		p
hics								
	1.02	(1.00, 1.05)		0.11				
r (female vs. male) [a]	1.65	(0.73, 3.74)		0.22				
orientation (any vs. heterosexual)	0.74	(0.51, 1.07)		0.11				
Black vs. White) [a]	1.19	(0.70, 2.04)		0.52				
ty (Hispanic vs. not)	1.83	(1.11, 3.00)	*	0.02	2.32	(1.28, 4.19)	**	0.006
ion (ref = High school or less)								
ne college or other degree	1.40	(0.84, 2.32)		0.19				
or higher	0.91	(0.48, 1.72)		0.77				
e (ref = Less than $10,000)								
,000 to $49,999	0.93	(0.48, 1.82)		0.84				
,000 or more	0.99	(0.30, 3.21)		0.98				
ty of the RCC								
of transportation (walks there vs. not)	0.75	(0.54, 1.04)		0.08	0.58	(0.38, 0.89)	*	0.015
o get there (within 15min vs. more)	1.41	(1.01, 1.95)	*	0.04	1.67	(1.11, 2.52)	*	0.016
Use								
ry stage (seeking vs. in recovery)	0.72	(0.42, 1.24)		0.23				
y substance (opioid vs. other)	0.80	(0.59, 1.07)		0.14				
ostance use (3+ vs. 1-2 substances)	1.29	(0.89, 1.86)		0.18				
Tobacco use (current vs. not)	0.96	(0.70, 1.30)		0.77				
Baseline Levels of Substance Use Outcomes								
Abstinent from all substances (in %, n)	1.25	(0.71, 2.18)		0.43				
Length of abstinence (1+ month vs. less)	1.29	(0.93, 1.78)		0.13				
Problem-free for 90 days (no days drunk, etc.)	1.15	(0.78, 1.69)		0.47				
Mental Health								
Quality of Life								
Quality of Life (EUROHIS-QOL)	1.63	(1.08, 2.46)	*	0.02	2.09	(1.16, 3.77)	*	0.015
Self-esteem (1 item, 1-10 scale)	1.11	(0.99, 1.25)		0.08	1.03	(0.88, 1.22)		0.705
Psychological distress (Kessler-6)	0.82	(0.59, 1.14)		0.24				
Addiction and Recovery Services Use								
Outpatient addiction treatment	1.31	(0.97, 1.76)		0.08	1.60	(1.11, 2.32)	*	0.013
Alcohol/drug detoxification	1.18	(0.83, 1.68)		0.36				

RCC participation for new attendees was associated with increases in length of abstinence, decreases in substance-related problems, and significant improvements in QOL, self-esteem, and decreases in psychological distress

Table 4 - RCC outcomes 3 months after starting at the RCC		Baseline all (n=275)		Baseline retained (n=138)		3-Month retained (n=138)		Change (n=275)			
		M/%	(SD/n)	M/%	(SD/n)	M/%	(SD/n)	b	95% CI	p	
Substance Use											
	Abstinent from all substances (in %, n) [a]	88.7	(244)	91.3	(126)	91.3	(126)	0.14	(-0.42, 0.69)	0.63	
	Length of abstinence (1+ month vs. less) [a]	64.4	(177)	65.2	(90)	75.4	(104)	0.49	(0.10, 0.87)	0.01	*
	Problem-free for 90 days (no days drunk, high, interferred) [a]	38.9	(107)	46.4	(64)	65.2	(90)	0.97	(0.57, 1.37)	<.0001	**
Recovery Assets											
	Recovery Capital (BARC 10 items, 1-6 scale)	4.8	(1.0)	4.9	(0.9)	4.9	(0.9)	0.00	(-0.14, 0.14)	1.00	
	Social support for recovery (CEST-SS; 9 items, 1-6 scale)	4.8	(1.0)	5.0	(0.9)	4.9	(1.0)	0.01	(-0.15, 0.17)	0.90	
Quality of Life (QoL) (in mean, SD)											
	Quality of Life (EUROHIS-QOL; 8 items, 1-5 scale)	3.4	(0.8)	3.5	(0.7)	3.6	(0.8)	0.14	(0.03, 0.24)	0.01	*
	Self-esteem (1 item, 1-10 scale)	6.2	(2.8)	6.4	(2.8)	6.7	(2.6)	0.41	(0.04, 0.77)	0.03	*
	Psychological distress (Kessler-6, 6 items, 0-4 scale)	2.3	(1.0)	2.2	(0.9)	2.0	(1.0)	-0.22	(-0.37, -0.07)	0.00	**

Note: M = mean, SD = standard deviation, b = estimate of TIME (ref=baseline); model includes significant predictors of 3-month within-window survey completion (i.e., mode of transportation to RCC, travel time to RCC, has utilized outpatient treatment, level of perceived social support for recovery) as covariates and models participants as nested within sites; all n=275 included in repeated measures model; ** p < 0.01; [a] = binary distribution modeled using GENMOD

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Could be due to the fact that “new” RCC attendees could be either seeking or in recovery. So, many might have already accrued some of these aspects of social support and elements of recovery capital and were attending the RCCs for other reasons…

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Important Research Design Limitations to Consider…

- **Largely cross-sectional without comparison groups-** estimates reflect those who are currently participating and cannot speak to relative benefit nor discontinuation/dissatisfaction with RCCs – future longitudinal, comparative research needed
- A lot was covered in this study with few resources (R21); **more detailed investigation and engagement with current members** (via more in-depth in-person interviews etc) may lead to higher follow-ups (in longitudinal work) and **enhanced data accuracy/quality**
- **Quantity of RCCs has expanded rapidly during the past several years**; observed **estimates here may have changed with increased availability and accessibility and changing standards and norms** as RCCs benefit from their own accumulating experiences and adapt services/practices to better engage/meet needs of potential participants

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Summary and Implications

This first systematic study of RCCs in one US region (New England and NY state) suggests some consistent/inconsistent preliminary findings reflecting themes of who uses RCCs, to what degree, and the types and degree of benefit…

- Findings from RCC Director report, cross-sectional survey of existing members, and short-term longitudinal study of new RCC members suggest individuals with primary opioid and alcohol histories, who have few resources and more severe clinical histories utilize RCCs; one in five are **young adult**; about one quarter identify as **sexual minority**; **Hispanic** ethnicity predicts engagement; about **50-60% current smokers; many in early recovery but substantial proportion use RCCs in first 5 yrs of recovery…**
- A **large variety of services** are **offered** and **utilized** and **highly valued** among current attendees; mutual-support groups, volunteer opportunities, utilized and highly valued; other aspects such as technology, family support; NARCAN training highly valued but offered less frequently…
- **Preliminary empirical support** from cross-sectional survey (with lengthier duration of RCC participation) … **for the idea that RCCs may uniquely provide access to recovery capital than in turn may enhance quality of life/funx, self-esteem, decrease distress and that these benefits in turn, help facilitate continued remission and strengthen recovery**
- Some discrepancies observed among new members, however, who, while showing benefits in reducing SUD problems and increasing continuous abstinence and QOL/Self-esteem, and decreases in distress, did not show increases in recovery capital and social support…

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Strategies to improve peer recovery support in rural communities:

- Partner with other local health and community facilities
- Increase incentives for staff to remain at workplace
- Establish partnerships with transportation services or provide transportation (esp. given travel time to RCC was strong predictor of engagement)
- Provide telehealth and remote recovery resources

Rural peer recovery support should be able to focus on getting participants well, as opposed to getting participants to the RCCs.


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THE University of Vermont HEALTH NETWORK
Central Vermont Medical Center

TURNING POINT CENTER OF CENTRAL VERMONT

Central Vermont Prevention Coalition

Assertively Linking People to Care: Building a Peer Recovery Coach Program in the Emergency Department

Mark Depman, M.D.

Department of Emergency Medicine

Central Vermont Medical Center (CVMC)

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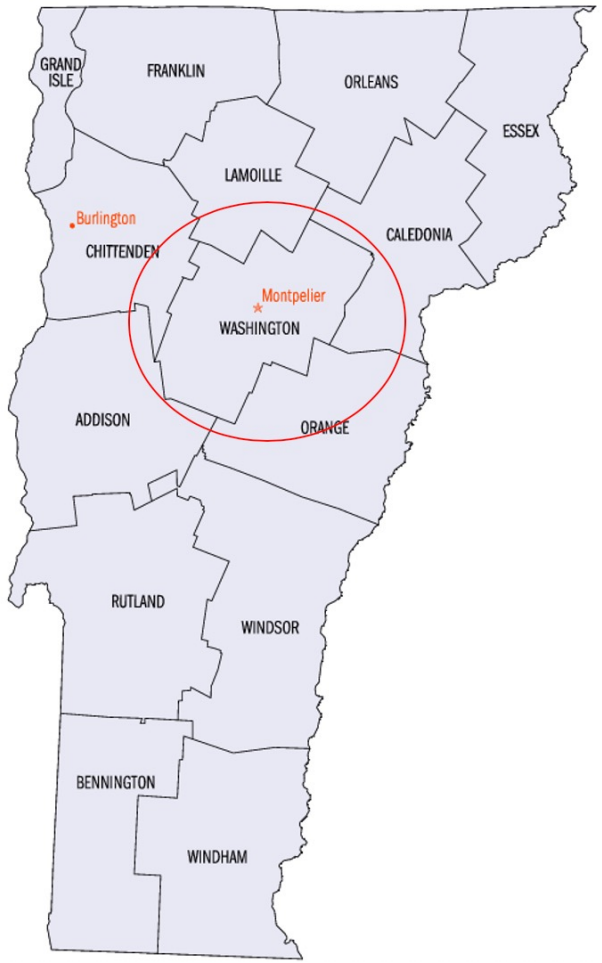
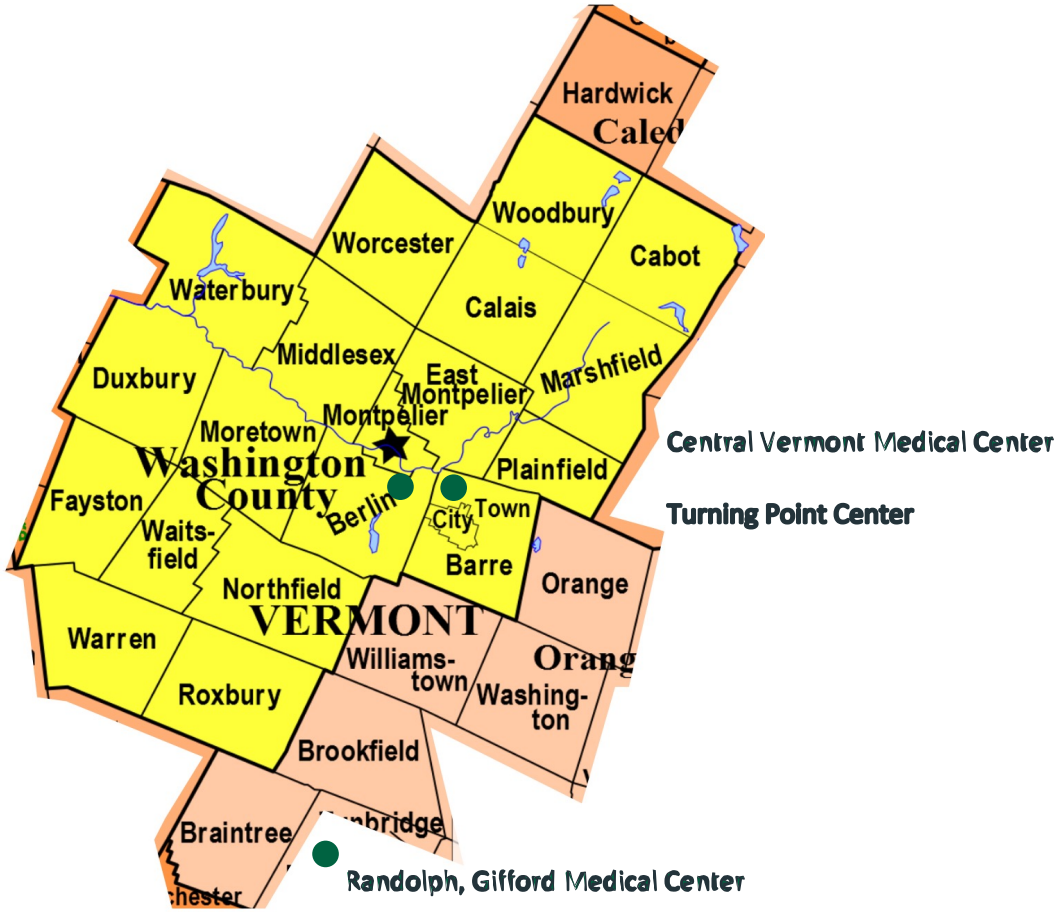
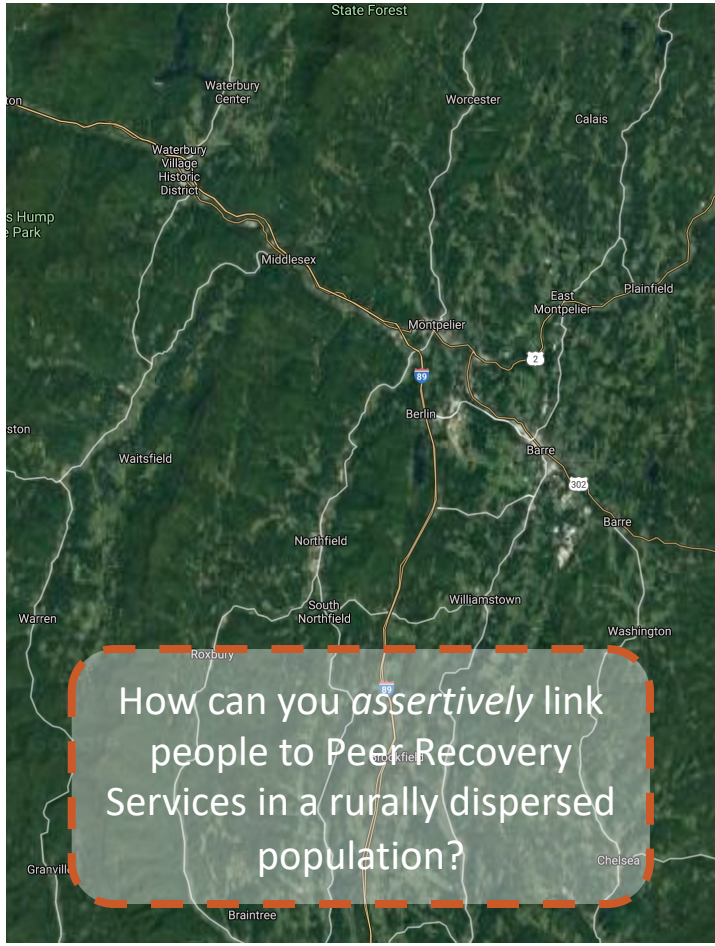
Peer Recovery Services:

Central Vermont's rural Barre Health Service Area







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Peer Recovery Services:

The Turning Point Center of Central Vermont's Scope of Services

- Open M, Tu, W 10am-5pm, W, F 10am-9m, Sa 6pm-9pm
- Meetings now are in-person and conducted via Zoom
- SMART Recovery 4 Point Program
- All Recovery Meetings facilitated by a trained person in long-term recovery
- Recovery Coaching program
- Making Recovery Easier Workshops
- Job and Career Counseling (VT DOL)
- Writer's Group
- NA and AA meetings (S, S, M, Th, F, F, Sa, Sa)

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Peer Recovery Coaches in the ED:

The Value Statement

There are many paths to recovery.

The ED is a unique locus of acute crisis for people throughout our rurally dispersed region. That creates an opportunity – an extraordinary moment in time - for PRC's to **assertively connect** with those people **and stay connected.**

Assertively connecting means being there.

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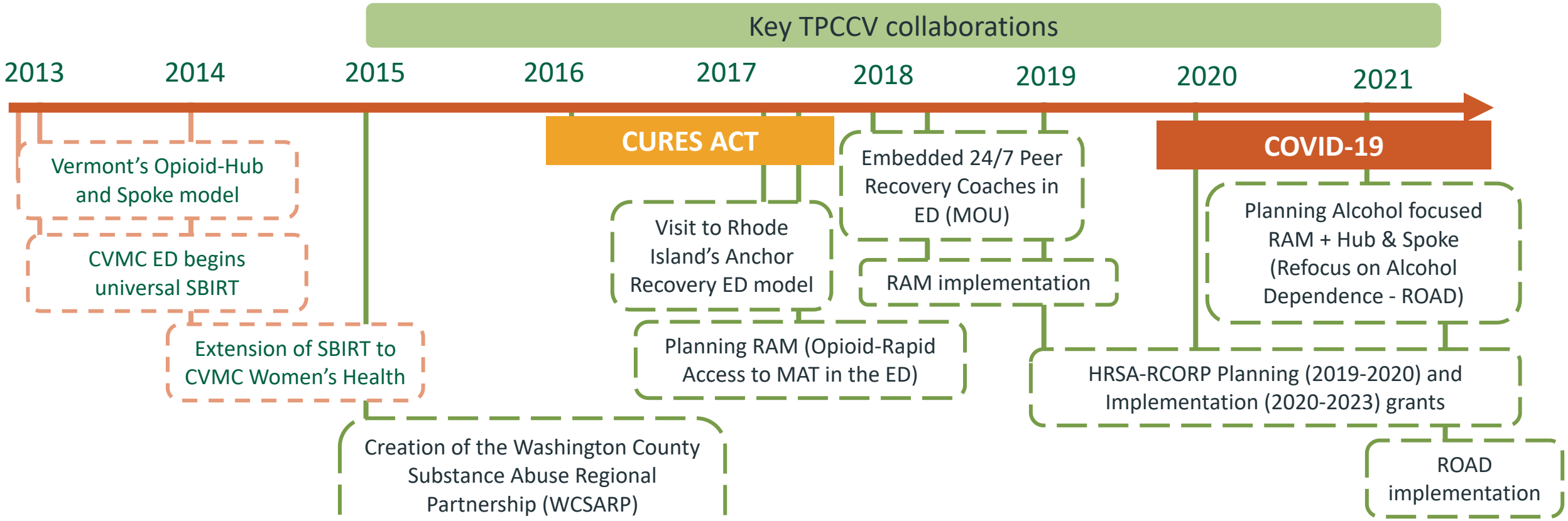
Overview of mileposts: Turning Point Center & CVMC



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Peer Recovery Coaches in the ED:

The Value Statement in a rural environment

There are many paths to recovery.

The ED is a unique locus of acute crisis for people throughout our rurally dispersed region. That creates an opportunity – an extraordinary moment in time - for PRC's to **assertively connect** with those people **and stay connected.**

Assertively connecting means being there.

- It also brings into focus **social determinants that will impact the success of recovery**
- PRC's in the ED work together on **a common goal** with the nurses, doctors/advanced practice providers, social workers **as part of the care team**
- Staff recognition of the PRC role and **lived experience** adds nuance and understanding to patient lives and reduces stigma
- PRC's are recognized as the glue that holds the continuum of care together during and after the ED visit, even to the distant towns in our region

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Peer Recovery Coaches in the ED:

The Role

- 24/7 availability; iPads during deep months of COVID before staff vaccinated
- PRC paged through EMR Order Set; intervention in ED with patient; may continue into hospital if admitted
- After discharge, attempts to contact once a day for 10 days then 3x/week for 4 weeks
- Once contact made, 30 days engagement by mutual consent
  - Last quarter: 124 total/67 unique participants with 91% engagement in follow up, contacted within 48 hours
  - Some patients who decline services later reach out to engage
- Data collection
- Communication with Case Management team
- Leverage resources from CORA: TracFones and medication lock boxes

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Peer Recovery Coaches in the ED:

Building Excellence and Sustainability

- **Successes**:
  - Training & supervision – Recovery Coach Academy; Coachervision (CCAR)
  - Teambuilding and support
  - Increasing opportunities in the ED and back at the Recovery Center for shadowing to build confidence and inner strength
  - All of this helps with retention in our challenging rural environment

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Peer Recovery Coaches in the ED:

Building Excellence and Sustainability

- **Challenges**:
  - Recruitment
    - Increasing need for technical and communication skills; comfort in hospital environment
  - Sustainable funding sources
    - Federal and state grants as funding sources are not sustainable
    - Models needed for including PRC services in bundled payments for care in a hospital, “hub” or “spoke”
  - Livable wage & benefits
    - Current hourly compensation model
    - Full time vs. half time employment
    - Lack of benefits

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Peer Recovery Coaches in the ED:

The Unexpected

- Hospital HR departments
  - Background checks and process to work through such issues have proven to be delaying, triggering, often leading to painful conversations
  - Educate your HR departments and help reduce stigma
    - “the very experience that ‘disqualifies’ me is what makes me great at my work”; “when people in recovery change their lives…they change their lives”

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Peer Recovery Coaches in Other Settings:

Demand– Demand– Demand

- **Already connected to**
  - Remote access to TPCCV programs throughout and beyond COVID
  - MAT teams and Hub
  - Montpelier and Barre PD
  - Washington County Treatment Court
  - Gifford Medical Center in Randolph (Orange County)
- **In development**
  - Leadership of regional PWLE Advisory Council
  - Pregnant and postpartum women's clinic
  - Regional 24/7 behavioral health crisis intervention team (CIT)
  - Recovery housing for mothers w/children in Barre
- **Need identified in**
  - Justice Center Circles of Support and Accountability (COSA) programs
  - Primary care practices/integrated behavioral health


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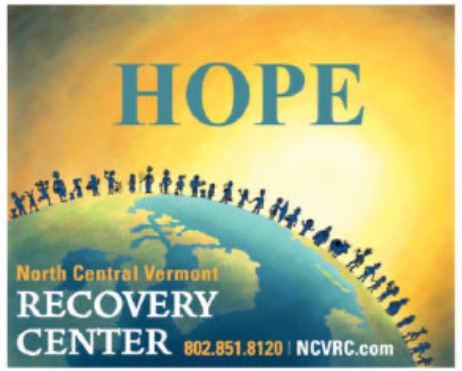

Peer Recovery Coaching: The Impact

Liza Ryan, Peer Recovery Coach

Turning Point Center of Central Vermont

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How did you become a Peer Recovery Coach?

Turning Point Center of Chittenden County

North Central Vermont Recovery Center

2017 2018 2019 2020 2021

COVID-19

Graduated from Recovery Vermont's Recovery Coach Academy

Joined UVMMC ED Peer Recovery Program in Burlington

Provided recovery support services in the General Assistance hotels that provide safe housing during COVID-19 to those experiencing homelessness

Joined Copley ED Peer Recovery Program in Morrisville

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Why did you become a Peer Recovery Coach?

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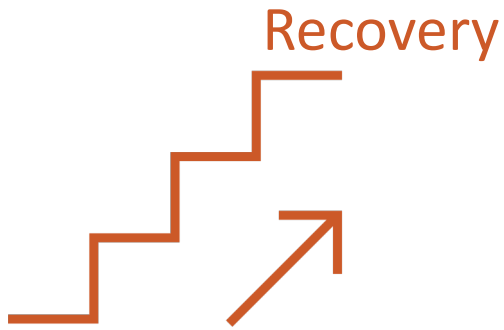
Why did you become a Peer Recovery Coach?

Recovery does not look the same for everyone

- Harm Reduction vs Abstinence Based
- Getting connected to services if there are co occurring mental health conditions

Different Paths to Recovery

- 12 step based programs
- SMART recovery
- Spirituality
- MAT and MAT support groups



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Why did you become a Peer Recovery Coach?

Engaging in the recovery community

Empowering those to connect with the available resources around them

- AUD and SUD can be extremely isolating
- “The opposite of addiction is connection”
- Helping to identify the community partners that someone would need to be successful in their recovery

For Example: Local Recovery Centers, Syringe Service Programs, Outpatient Treatment, Recovery Meetings, Connection to Primary Care Physician, Recovery Housing, Economic and Food Assistance

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Why did you become a Peer Recovery Coach?

Individual Support

Meeting people where they are at in their recovery journey

- You can start working with a recovery coach at any point in your recovery
- Working as an ED Recovery Coach there may be more immediate needs such as safe housing and access to MAT
- Those in early sustained recovery may need support around finding meetings or developing healthy habits and routine

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How do you think your job is influenced by working in a rural community?

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How do you think your job is influenced by working in a rural community?

Transportation and Accessible Services

- Many resources are not within walking distance
- There are long drives to MAT providers, which impacts childcare, employment, and many other areas of life

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How do you think your job is influenced by working in a rural community?

Lack of Connection and Visibility

- Where to find support and “your people”
- Finding and connecting with service providers
- Smaller communities = Less recovery meetings

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How do you think your job is influenced by working in a rural community?

Safe and Affordable Housing

- Practically no affordable housing in Lamoille County, difficult to move away from previous housing where there may have been prior substance use

- Often difficult to apply for apartment housing due to employment history and/or involvement with CJ system

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How do you believe Peer Recovery Coaches contribute to the recovery landscape, especially in smaller rural communities?

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How do Peer Recovery Coaches contribute to the recovery landscape in rural communities?

Serving an interim and/or long-term role

- With less resources centered in rural communities, recovery coaches can work with people longer to ensure they are being supported and held until connecting with more service providers
- You can work with someone in the ED and continue to serve as their primary recovery coach even after EDRC team engagement has ended

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How do Peer Recovery Coaches contribute to the recovery landscape in rural communities?

Brief Interventions

- ED vs Recovery Center

Emergency Department	Recovery Center
Team of 4-5 coaches is on call 24/7	People call center to complete intake
Access to coach within 30mins	2-3 day intake and assignment process
Often connecting to higher level of care (residential, hospitalization)	Coaching used as step down for sustained recovery support
Often someone's first introduction to peer recovery services	May have familiarity with recovery center or have been connected through other provider

- Recovery coaches should be in every ED, providing peer support and offering introduction to recovery services 24/7

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How do Peer Recovery Coaches contribute to the recovery landscape in rural communities?

Understanding the recovery landscape

- The in's and out's of what providers do vs what they do not do, can be different in rural communities
  - Prescribing MAT in the ED
  - RAM program in Lamoille County (https://lamoillemat.org/)
- Cellphone distribution in Copley Emergency Department through CORA

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What is the hardest part of the work for you?

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What is the hardest part of the work for you?

Waitlists and inadequate resources

- There is a shortage of long-term residential beds in the state of VT
- Lack of understanding around the urgency of people reaching out for help
- Support and housing for those awaiting residential bed (maybe still in active addiction or unable to return to previous housing)

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What is the hardest part of the work for you?

Challenging Stigma

- Education with primary care physicians, mental health service providers, etc
- Lack of recovery visibility in rural communities
  - With resources wide spread among communities, there lacks a central place for those in recovery to be
- Resources do exist
  - NCVRC and Jenna's Promise

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What is the most rewarding part of the work for you?

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What is the most rewarding part of the work for you?

Seeing people's continued success

- How recovery has enriched and changed their life
- Seeing people engaged in the community and active in others recovery
  - Patients in ED from 2019 now serving as recovery coaches

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What is the most rewarding part of the work for you?

Self worth with my own recovery

- My own history of addiction has added value to someone else's life
- Instilling hope in others that I have been at that same "bottom" and have been able to achieve recovery with the support of others


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Questions & Discussion

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Thank you participating in this
UVM CORA Community Rounds Workshop Series

Please join us for our upcoming Lunch and Learn as part of VCBH's conference on October 8th, 2021:

Rural Vaping and Tobacco Use: Prevalence, Considerations, and Interventions

With Stephen T. Higgins, PhD, Andrea Villanti, PhD, MPH, and Bethany Raiff, PhD

Center on Rural Addiction

UNIVERSITY OF VERMONT

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