Progress Report: Vermont's Recovery Centers & Vermont Recovery Network

The peer recovery support system known as the Vermont Recovery Network (VRN, or the Network) today is acknowledged as one of the nation's preeminent statewide peer recovery systems. This model has been developing for well over a decade to achieve this status. The history and projected course of that development is documented here.

Background:

Our beginnings. In 2001, the Vermont legislature began providing VDH/ADAP with funding for the development of community-based nonprofit recovery centers. ADAP supported Mark Helijas, the director of the Turning Point Recovery Center, which was being replicated, to develop boards on which a majority of members self-identified as people in recovery. The centers were established to provide recovery support in communities around Vermont. Initial RFPs specified that recovery centers be local, consumer-driven, nonresidential facilities that provide peer supports, sober recreation activities, volunteer opportunities, and community education. Centers were to help people maintain alcohol-free and drug-free lifestyles with opportunities to improve their quality of life through supports appropriate for diverse age, gender, and cultural groups.

The initial RFPs described recovery centers as places where all Vermonters could find a sympathetic ear and information about recovery and substance abuse services in a safe, drug-free and alcohol-free environment. Recovery centers were expected to provide nonclinical services to help guests establish community connections to secure employment, housing, and social services. Recovery centers were funded to help people maintain recovery, prevent relapse, and, should relapse occur, return to recovery. Centers were expected to provide welcoming environments and support people of all races, spiritual approaches, sexual orientations, disabilities, and recovery paths, including medication-assisted recovery. They were required to include people involved in all recovery approaches found across Vermont.

The initial RFPs also specified that recovery centers collect outcome data, while acknowledging the need for visitors to maintain personal anonymity. Centers began the process of tracking numbers of visits and numbers of recovery meetings held, and distributing participant surveys.

In 2006, representatives from the seven existing recovery centers approached the legislature requesting help with the development of recovery centers, boards, and recovery support approaches. The legislature created and funded the Vermont Recovery Network with the following language, "The Department of Health shall be advised by an executive council of Vermont's recovery center network on an ongoing basis to prioritize service and funding needs for recovery centers, to assist with the review of recovery center funding proposals, and to provide recommendations for disbursement of funds to the recovery centers and their support needs. This executive council will consist of a board member of each recovery center. The executive council will hire a network coordinator with the appropriation in subsection (f) of this section. The network coordinator will work for the executive council and provide technical assistance and training to recovery centers. The executive council, working with the department of health, will have oversight of the recovery centers."

The centers began considering how to create the Vermont Recovery Center Network and hire someone to serve as Network Coordinator, the person tasked with supporting the development of

the recovery centers and their recovery support services. The centers specifically chose the term *coordinator* rather than *director* because they envisioned that this new nonprofit would be run in a way consistent with peer-recovery values and norms, which include participants in management. They chose Mark Ames as coordinator and Vermont Recovery Network (VRN) as the organization's name. They defined the nonprofit's purpose: "The Vermont Recovery Network is dedicated to supporting and connecting efforts that provide recovery support services."

The Network founders wanted recovery centers to foster the selfless acts of service those in recovery traditionally have offered to people considering the life changes known as recovery. People who have evolved to become positive, less self-absorbed, optimistic, and realistic about the degradation they experienced before finding recovery feel an obligation to share these gifts with others seeking recovery. The evolving Network strives to maintain the magic and effectiveness of the recovery process that the 12-step recovery experience offers, capturing the essence of that recovery experience and making it attractive to people on *all* paths to recovery. Recovery values developed over the last 85 years, such as attraction, inclusion, anonymity, equality, and "keeping it simple," have informed this work.

The Network Coordinator supported efforts to create bylaws, organized regular Network business meetings, and helped centers build boards. Key to the early developmental process was sharing ideas about how to provide recovery supports for people on all paths to recovery and sharing approaches for delivering this new service model in recovery centers. Centers adopted a uniform volunteer screening tool and developed an "Oversight Process" based on the original legislative language that created the Network. This peer-governance approach was designed to respond to any issue that "may need attention before it negatively affects a center's capability to provide effective recovery support services and/or brings into question the viability or integrity of the Network."

Sharing approaches for providing services, managing volunteer workforces, and providing volunteers with training led to the development of consensus on using a recovery-support approach based on listening, considering a person's willingness to change, and asking motivating questions. Recovery values avoid telling anyone what to do and avoid any power differential between the persons providing and receiving recovery support. This process was accompanied by a growing commitment to providing uniform statewide services, so that what one experienced in one center would be consistent with what happened in another center. The advent of "recovery coaching" trainings, which were based on the same principles, led the Network to develop formal protocols for the provision of recovery coaching in recovery centers.

Recovery coaching. Proving the effectiveness of recovery coaching in community recovery center environments has been made possible by state demonstration funding. AHS Challenges for Change grants and VDH/ADAP RROSC demonstration grants funded recovery coaching programs and the collection of outcome data. The Network centers participated in the development of a data collection tool, mobilized and trained teams of recovery coaches, and contracted for a study, which **documents that recovery coaching leads to statistically significant positive changes in participants' lives**. (See: https://vtrecoverynetwork.org/PDF/VRN_RC_eval_report.pdf)

VRN centers voted to to partner with other New England peer recovery providers and the Connecticut Certification Board in the development and implementation of a peer-driven recovery coaching credential, which could be made available to Vermont's recovery coaches. After considerable developmental work, our Network now has Certified Addiction Recovery Coaches

(CARC) functioning with a Nationally recognized credential. [Note: Optima Health has just begun to reimburse certified recovery coaches in RI at the rate of $50 an hour for the provision of recovery coaching, utilizing their peer-driven model.]

Connecting people in treatment with recovery supports is critical to their ongoing successful lives as people in long-term recovery. The Network has adopted the position that a peer recovery system, capable of providing ongoing community-based recovery support, is a critical element in a system of care that responds to the chronic nature of addictive disease. We support the concept of providing recovery services in treatment settings, but our group of peer service providers firmly believes that recovery services should be provided only with support from others in recovery and be anchored in recovery services organizations, whenever possible.

Our infrastructure: Developing standards. The Vermont state senate's Appropriations Committee initiated the Network's development of standards for the provision of recovery services in 2012 with the following language. "c) Prior to the issuance of grants to the recovery centers in fiscal year 2013 and thereafter, the recovery network advisory board shall recommend to the department of health how such funds should be allocated by center.
(d) The advisory board shall research national standards of peer supports and core services to be provided by recovery centers. By September 15, 2012, the board shall develop a set of standards, core services, and monthly performance measures to be submitted for approval to the department of health – alcohol and drug abuse programs and the department of mental health. The board may collaborate with the department of health, the department of mental health, and the designated agencies regarding standards, core services, and performance measures as well as optional additional services. To the extent possible, adoption of the standards, core services, and performance measures shall be a condition of state grant funding in fiscal year 2013 and shall be a requirement for grant funding in subsequent fiscal years."

The promise of increased funding with the development of more robust organizational and financial accountability spurred the development of the Network's documents on Standards, Core Services, and Ethical Guidelines. Our peer communities have engaged in considerable debate about how much structure peer recovery services should have, but we achieved consensus in developing this next important piece of our peer-governance structure.

The original legislative language that funded the Network suggested a strong VDH relationship with the Network. The Network has implemented the model described in 2007 and developed policies (Oversight), procedures (such as recovery coaching protocols), and standards that support the model. The consensus-driven work all centers have done to establish and refine our peer-governance system through a series of unanimous votes has repeatedly reaffirmed the recovery centers' collective commitment to this process. Unfortunately, due to staffing constraints, VDH/ADAP has not been able to dedicate direct staff time in support of the Network's Oversight and Standards review processes. ADAP staff have been very supportive of our efforts, but are consumed with the many other activities they have been charged with managing.

Current Initiatives

Board development process. The Network sought and received support from VDH/ADAP for a board development retreat. The retreat planning process focused on both the development of individual centers' boards and the development of the Network's board representation. The retreat

reinforced efforts to expand board reach into host communities and devoted considerable focus to policy governance. The original recovery center board members were active participants in running their fledgling centers. Discussions focused on evolving this model into one where boards create goals and objectives and support staff through guidance and fundraising.

The legislative language that created the Vermont Recovery Network specified an "executive council (that) will consist of a board member of each recovery center." During the formation of the Network as a 501(c)(3), this language was interpreted to mean that the board of the nonprofit representing all of the recovery centers must include a representative picked by each individual recovery center board. Over time, many sitting board members have served as representatives at our regular Network meetings (every six weeks), but delegating the task of representation to center directors has now become general practice. We examined this trend during our recent VRN board retreat because this practice didn't appear to be consistent with our discussions of best board practice. Discussions have continued and varying proposals have emerged about how we might best incorporate board involvement in VRN governance as a result of the retreat. We are planning a second retreat to consider this issue further.

Pathways to Recovery Project. As a result of our demonstrated success in providing recovery supports, the Vermont Recovery Network received Federal funding in October to implement a pilot project, Pathways to Recovery, which will provide support for Vermonters in opiate treatment. People in opiate treatment have not had consistent access to welcoming peer recovery groups and recovery support services. All of Vermont's recovery centers now host half-time "Pathway Guides," paid by VRN, who are working with opiate treatment providers and receiving referrals for one-on-one support and/or facilitated peer recovery support. Pathway Guides will increase available staff time at each participating recovery center and demonstrate the benefit of providing expanded peer recovery support for people in recovery from opiate addictions. Because this grant doesn't cover supervision or office space, Vermont recovery centers are stretching already tight budgets to support this program. These part-time experts on the recovery process will help people seeking support for opiate addiction, but because their employment is limited to accomplishing VRN's grant objectives, they will be unable to meet the recovery centers' general staffing needs.

Our Pathway Guides will function as ambassadors of recovery and help people in medication-assisted treatment to develop their own vision of how their lives could become more comfortable and satisfying in ongoing recovery. Our approach to providing information and peer support for people recovering from addictive disease helps them take responsibility for managing their lives with this chronic health condition, just as people with diabetes, asthma, or heart problems have traditionally benefitted from information and targeted recovery support.

We have already developed introductions to various recovery approaches such as: All Recovery meetings, Making Recovery Easier groups, and our pilot Recovery is the Solution groups, which answer the question, "Why would I want recovery?" Recovery centers host these groups to introduce participants to others in recovery, helping them to create their own webs of recovery support.

The Pathways to Recovery project will make it possible for our team to refine these recovery approaches, while working with those providing medication-assisted treatment. Guides will coordinate with treatment professionals to determine mutually agreeable ways to introduce people in treatment to personally directed recovery approaches. Many providers and centers have regularly scheduled visits where center representatives introduce themselves and the recovery supports

available in recovery centers for people in treatment and during ongoing recovery. Increased staff support will allow us to expand these efforts.

Building Network infrastructure. Our SAMHSA opiate-treatment support grant has demonstrated the importance of expanding the Network's capacity for providing administrative and data collection support for the individual recovery centers. Having a single point of contact for securing, distributing, managing, evaluating, and reporting on the use of funds provided for statewide recovery support projects, delivered by individual the recovery centers, has tremendous potential for increasing funding streams for the provision of recovery support by the individual centers. VDH Deputy Commissioner Barbara Cimaglio has long advocated that centers seek funding from other sources, including other AHS departments. The recovery centers voted to respond to SAMHSA's request for proposals to develop statewide networks for the provision of recovery supports. "The purpose of this program is to expand the capacity of addiction recovery community organizations (RCOs) through the development of an organized statewide network. There is a need for greater recognition of the scope and value of addiction recovery community organizations, peer recovery supports and services, and the need for the peer voice to be represented in state-level policy planning and implementation." The proposal was structured to create a system similar to the one the Vermont legislature created, but including an infrastructure for distributing, managing, and evaluating the use of funds.

Refining Standards review process. Last year, Vermont recovery centers began to use their peer Standards review process. (See https://vtrecoverynetwork.org/PDF/Standards.pdf) This initial exercise was the first trial run for reviewing each center's compliance with the following service areas: 1) Organizational Leadership, 2) Organization Quality, 3) Operational Standards, and 4) Standards for Recovery Services. Each center received a visit from a site review team. Teams consisted of the Network Coordinator and at least one other center director. Most of the review teams included at least three reviewers. The centers agreed that this first attempt at standards review would be considered a trial run and the results would be distributed only to the participating centers to help them refine their internal processes.

The series of site reviews revealed that we needed to modify our process to quantify and evaluate the effectiveness of recovery centers' approaches to providing recovery support services. The first identified improvement area was to develop a more objective approach for evaluating the various service areas from the perspective of people who are visiting, collaborating with, or referring people to the recovery centers. The initial standards review approach relied too heavily on self report, which had the potential for being unrealistic. The Network team recommended the development of community surveys and a process for utilizing AHS district directors as partners in distributing the surveys.

The second approach for developing a more objective means for considering Standards compliance was to involve board representatives from each individual center board on the review teams. The idea of increasing individual center board members' understanding of the work centers are doing, combined with their inherent objectivity and desire to improve the systems, made this a logical solution. We see an opportunity to increase objectivity by using board member review team participants in site reviews at other centers, but the first step will be to include board members in our evolving Network review process.

VRN's approach to funding distribution. The Network's history of governance, particularly related to funding, has included deliberations that have led to consensus. The recovery value of having "our common welfare come first" led to the Network commitment of adopting a uniform funding/statewide services approach until all centers reached a level of support sufficient to have paid staff on site during all hours a center is open. The Network adopted this position years ago and keeps reaffirming that, to have uniform recovery services available across the state, each center needs sufficient staff to provide consistent recovery support and a safe environment. The group reached consensus on the position that once every center had sufficient staff to provide basic operations, it would be appropriate to purchase additional recovery support services based on the area's population base (both its size and its challenges).

Earlier this winter, the current opiate crisis led center representatives to make an exception to this practice of recommending equal funding to all centers. As a recommendation for the FY '14 Budget Adjustment Allocation, representatives voted to recommend additional support for the recovery center with the largest walk-in population of people seeking recovery, because the levels of still-active opiate users trying to access the center were affecting that center's safety. The Network representatives acknowledged this special situation, while voting to otherwise maintain existing policy, recommending the equal distribution of remaining funds. The Network still envisions a system where people in recovery seeking services anywhere in the state will find a comparable level of service and safety, no matter where they visit. This goal is especially important as the hub-and-spoke and Blueprint for Health initiatives become established.

How Recovery Centers provide unique solutions Vermont has begun the practice of using the crisis of an arrest as a motivator for encouraging people who commit lower-level crimes to seek treatment and recovery supports as a way to avoid becoming entangled in the justice system. Those people with addictions who are successful in their recovery efforts require ongoing recovery supports to help prevent the cycles of recidivism. Our experience suggests it would be simplistic to rely solely on treatment to bend this curve. We need to expand the webs of community support for those leaving justice system interventions and custody. We are beginning to engage these people in communities of recovery instead of the communities of addiction that fuel the cycles of recidivism.

Many of the participants in Burlington's initial experiments with rapid interventions were referred to the Turning Point Center of Chittenden County for recovery coaching after being identified as having trouble with drugs and alcohol, making them potential candidates for direct immersion in recovery. Burlington State's Attorney T.J. Donovan's glowing report on the effectiveness of what was first called "rapid arraignment" included many of the same people who provided the basis for an independent study showing the effectiveness of recovery coaching.

The Vermont Recovery Network and our evaluators at Evidence Based Solutions (EBS) have developed a tool for documenting the effectiveness of recovery coaching. It tracks the participants' use of treatment, justice, medical, and social services over time and documents progress in developing self sufficiency through the use of a Self Sufficiency Matrix (SSM). The SSM was developed by the Pennsylvania State Department of Health, Bureau of Drug and Alcohol Services Case Management Workgroup (Pennsylvania Department of Health, 1999). It assesses an individual's level of supports across a number of domains, including housing, childcare, education, vocational, employment, basic needs, transportation, substance abuse treatment, legal, mental health, physical health, family/social, and life skills. Results are used to develop an evolving recovery plan, addressing highest areas of need first.

The SSM has demonstrated that, over time, individuals who take part in recovery coaching experience **statistically significant increases in their recovery capital** and develop increased social connections. Connections with new peer groups are critical to achieving ongoing recovery. The findings have also documented positive changes in the lives of these people in recovery. Their **statistically significant reductions in the use of the courts, corrections, hospitals, emergency rooms, and detoxification programs were accompanied by statistically significant increased use of primary care.** This data indicates the potential for significant savings and demonstrates the need for broader study and increasing the use of this approach.

(See https://vtrecoverynetwork.org/PDF/VRN_RC_eval_report.pdf)

Recovery coaching is a promising practice; all eleven VRN centers have coaching teams. **We view recovery coaching as a more formal and intensive version of the peer-to-peer supports our centers have always provided.** The formal relationship between a person in recovery and a coach has provided us with an opportunity to document the outcomes that result from supporting someone in taking responsibility for changing their life and finding a personal pathway to recovery.

Projected Additional Results:

Assuming additional funding thanks to the governor's proposed budget increase, recovery centers acknowledge the need to produce more robust outcome data. While maintaining the welcoming, anonymous nature of our recovery centers, we hope to expand on our ability to track additional center collaboration with providers and collect individual outcome data that demonstrates the effectiveness of specific recovery services, such as recovery coaching and Making Recovery Easier groups, while avoiding collecting data on individual center visitors. There has long been concern that asking for participant information as a requirement for use of centers would have a chilling effect. Recovery centers have never had sufficient resources to hire full-time directors, recovery coach coordinators, operations managers, or volunteer coordinators, but with sufficient staffing, centers would be in a position to commit to providing more rigorous outcome data.

We propose increased documentation of referrals to community partners. Network centers all currently use a robust online data entry system, but staff at each center is insufficient to support the uniform collection and submission of data. In the absence of staff to record all referrals to treatment and other community services, reliance on volunteer staff to report many of the data fields we have identified has led to significant underreporting. Three years ago, centers voted to refrain from using these measures in reports, because the levels of underreporting created the impression that centers made limited referrals to other services, when in fact, volunteers and staff do connect people with myriad services. Our center guests do reference referrals to other services on participant surveys, but the data collection at centers was not sufficient to document these referrals. With increased staff support, our centers could begin to track referrals immediately.

The recovery coaching data collection tool has already proven its effectiveness in documenting statistically significant changes in the lives of participants in the recovery coaching process. Given sufficient staffing support, centers have agreed to expand their commitment to providing recovery coaching and collecting outcome data. To this point, the recovery coaching programs managed by part-time directors have suffered from neglect. The model the Network centers developed three years ago presumed the presence of a recovery coach coordinator who worked at least part time to coordinate teams of recovery coaches and manage the data collection process. Increased staffing

support will make it possible for centers to revitalize their recovery coaching programs and collect data.

Making Recovery Easier (MRE) is a six-session, peer-led group that is an evidence-based practice. MRE has proven effective as an introduction to the recovery process and has grown to become a required activity for drug court participants. It represents a structured group to which other agencies can refer participants, with assurance that participants can receive a certificate of attendance and be introduced to the recovery process and connected with others in recovery. We propose to use increased budgetary resources for the Network's evaluation efforts to develop an outcome tool consistent with the one currently being used with recovery coaching participants. Our evaluation partners, Evidence Based Solutions (EBS), have been willing to help with this process, but we have not had sufficient funding to do so.

What sort of outcomes are centers already producing?

Relevant facts: Over the last eight years, one-third of the people who use recovery centers (N=8,023 surveys) have moved directly from substance use to recovery without the need for treatment, but recovery services receive less than 1% of the current addictions budget.

Last year guests made 168,369 visits across the network's eleven recovery centers. Centers collected 1,152 "Participant Surveys" from a representative sample of visitors. We know that our average visitor comes 12.45 times per month. Based on the total number of visits across all 11 recover centers and the average number of visits per person per month, we estimate that **recovery centers hosted 13,524 different individual visitors**. The total annual state support for recovery centers is $714,901. Providing recovery support via the 11 recovery centers costs an average estimated **$52.86 per person served**, which is more than matched by volunteers providing $1,040,580 in support (2012 National Independent Sector rates). Our recovery coaching study documents the potential increased savings that can be accrued from fielding a broader team of trained recovery workers.

We serve more men (55%) than women (45%). Our average visitor is just over 40 years old. Centers have many occasional visitors: an *average* of more than 100 regulars who come for 2 or 3 visits a week, and a small revolving population of high-utilization visitors coming daily until their lives stabilize. Our visitors get their lives in order, find jobs, find housing, repair the damage caused by addictive behaviors, and function in recovery as productive members of their communities—often for the first time in their lives.

Upon initiating their use of recovery center supports, 26% of individuals we serve report being on probation or parole and 24% report having been released from probation or parole. Interestingly, while 54% report criminal incidents/ involvement before involvement at recovery centers, **only 8% report new criminal incidents/involvement after becoming involved with recovery centers**.

Last year, 75% of our guests reported current or past participation in mental health services and/or supports. With respect to treatment utilization, approximately 72% of survey respondents reported receiving substance abuse treatment in the past; 29% had been in treatment during the previous 30 days; and 27% reported never having attended treatment. Documented increases in collaboration with treatment providers during the last year tracks with this increase in treatment utilization, but we also continue to demonstrate the power of peer recovery for supporting people not interested in, or able to participate in, treatment.

We've created a statewide recovery system with standards, accountability, and evidence-based recovery support services that address the chronic nature of addictive disease. People who suffer from relapse do not necessarily need repeated treatment experiences. Vermont's recovery centers have grown to become a front door to Vermont's treatment system, as well as a destination after treatment. In some cases, centers offer support until treatment is available; in others, our recovery supports provide a direct path to a life in recovery. Treatment is a valuable experience for many, but people in recovery regularly and routinely acknowledge the need for ongoing supports that help maintain their lifelong recovery process.

Submitted by Mark Ames, Coordinator, Vermont Recovery Network – April 17, 2014