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Short communication

Post-overdose follow-up in the community with peer recovery specialists: The Lake Superior Diversion and Substance Use Response Team

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A B S T R A C T

Background: As the overdose epidemic continues to worsen, nonfatal overdose calls for service represent a critical touchpoint for intervention. While most studies have focused on law enforcement led post-overdose follow-up, the current study describes the programmatic characteristics and outcomes of a non-law enforcement post overdose program comprised of peer specialists embedded within a local police department.
Methods: We examined information on 341 follow-up responses occurring over a 16-month study period using administrative data. We assessed programmatic characteristics including demographic information on clients, referral source, engagement type, and goal completion.
Results: The results indicate that over 60% of client referrals ended in the goal of in-person contact. Of those, about 80% went on to complete an engagement goal with the peer specialist. We found no significant variation in client demographics and referral source or follow-up engagement (in-person or not); however, client referrals from law enforcement first responders, the most common source, are significantly less likely to result in an in-person contact, though, if contact is made, similarly likely to complete an engagement goal.
Conclusions: Post overdose response programs that do not involve law enforcement are exceedingly rare. Given that some research has shown that police involvement in post overdose response can have unexpected, associated harms, it is important to assess the effectiveness of post overdose programs that do not involve the police. Findings here suggest that this type of program is successful at locating and engaging community members into recovery support services who have experienced an overdose.

1. Introduction

The illicit drug market has continued to transform over the past two decades in ways that contribute to escalating overdose rates globally (Volkow et al., 2019). In the United States, nearly one million died from a drug overdose over the past twenty years. Most of these overdose deaths were opioid-related, though the type of opioid has varied across multiple waves, each resulting in more deaths (Ahmad et al., 2022). Since 2013, increases in overdose deaths are primarily the result of illicitly manufactured fentanyl, a synthetic opioid 50 times more potent than heroin (Ciccarone, 2021). Fortunately, opioid-related overdoses can be reversed through administration of naloxone, an antagonist that reverses respiratory depression caused by opioids. In most jurisdictions emergency medical services (EMS) are deployed to all poisoning events, regardless of the substance type, and have been equipped with naloxone since the 1970s (Sternbach et al., 1980). As the overdose epidemic has accelerated, it has become common practice to equip other first responders, particularly law enforcement, with naloxone. In many jurisdictions, law enforcement respond to all poisoning events and sometimes are first to arrive on scene (Pourtaher et al., 2022; Pozo, 2022). Research suggests law enforcement can effectively administer naloxone (Fisher et al., 2016; Rando et al., 2015); however, there may also be drawbacks as police regularly confiscate personal belongings, force overdose survivors to go to the hospital, and make it more likely that an overdose event results in an arrest (Lowder et al., 2020; Ray et al., 2022; Smiley-McDonald et al., 2022).

From a public health perspective, nonfatal overdose represents a critical touchpoint for intervention (Larochelle et al., 2019) to reduce risk of a fatal overdose. Indeed, hospitals in particular appear well positioned to play a crucial role; however, some patients refuse transport to the hospital after a nonfatal overdose (Ray et al., 2020; Wampler et al., 2011), or do not find a hospital setting conducive for starting recovery (Pollini et al., 2006), and not all jurisdictions transport overdose victims to the hospital as there remains no established standard of care for persons post overdose. In response, many communities have developed multi-agency collaborations to provide a follow-up response to community members after a nonfatal overdose with the goal of referral into community-based treatment and services. Although there appears to be great variability in response efforts, research has focused almost exclusively on law enforcement driven responses.

National prevalence of post-overdose follow-up efforts suggests most programs include law enforcement during the follow-up, most often with EMS (Ray et al., 2023). Research on these efforts has been limited primarily to case studies and state-wide surveys with findings that

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suggests little consistency in the practices, partners, or services provided and largely focused on efforts led by, or that include sworn law enforcement in the follow-up response with little rigorous evaluation of effectiveness (Canada and Formica, 2022; Davoust et al., 2021; Donnelly et al., 2022; Formica et al., 2018, 2022; Tori et al., 2022; Wagner et al., 2016). Important concerns have been raised about post-overdose response involving law enforcement, from unintended effects through increased mistrust of social services (Doe-Simkins et al., 2022; Latimore and Bergstein, 2017; van der Meulen et al., 2021; Wagner et al., 2021) to specific activities like "warrant checking," prior to outreach that might ultimately undermine program goals (Tori et al., 2022). Law enforcement presence after an overdose could lead to a negative impact on willingness to engage in follow-up or accept assistance as research with overdose survivors suggests concerns about law enforcement involvement in post-overdose interventions resulting in further criminal legal entanglement (Wagner et al., 2019).

In this short report we describe such a program that is facilitated by peer recovery specialists. Importantly, the team is diverse in terms of substance use background (e.g., stimulants and opioids), recovery experience, and race-ethnicity such that they are representative of the community they serve. We describe the characteristics of this program in detail and provide evidence of feasibility by exploring client characteristics and service engagement efforts to begin developing an evidence-base around post-overdose response efforts that address concerns expressed among those with lived nonfatal overdose experiences.

1.1. Setting and methods

In February 2019, The Lake Superior Diversion and Substance Use Response Team (SURT) started working directly with clients following non-fatal overdose. The team is embedded within the Duluth Police Department which employs approximately 150 sworn officers. Duluth is in St. Louis County, Minnesota with a population of 86,700 in the city limits and 290,000 in the metro area which includes Superior, Wisconsin (Douglas County). While the overdose rates in Minnesota are generally lower than other US states, the overdose rates in St. Louis County are consistently higher than the state average and have closely mirrored the national trends, increasing dramatically over the past two decades over multiple waves shifting from prescription opioids, to heroin, and finally to illicitly manufactured fentanyl.

The SURT consists of four peer recovery specialists and a licensed social worker (LSW) with alcohol and drug counseling certification, all of whom have physical workspace within the police department and are employed as civilian staff. The LSW is supervised by a contracted Licensed Independent Clinical Social Worker from the local drug and alcohol treatment center and three of peers are supervised are supervised by the SURT project manager, who is also a certified peer specialist, and who reports to law enforcement personnel. They coordinate regularly with an incident analyst (also non-sworn civilian staff), whose role is to identify overdose follow-up opportunities in the community. The incident analyst maintains a database with information from overdose calls for service where police were present. Peer specialists use this database to facilitate outreach through phone, social media (e.g., messaging or chatting), and in-person follow-up to either the individuals home address (if known) or the address where the overdose event occurred. As the SURT became established, peer specialists also cultivated direct law enforcement referrals (e.g., a text or email from a responding officer), as well as referrals from community members and agencies. Regardless of referral source, SURT maintains a secured database, unavailable to others in the agency, that confidentially tracks client contact information.

In this short report, we are unable to assess program effectiveness but instead examine SURT administrative records to provide evidence of feasibility by exploring client characteristics and service engagement efforts. While the program peers have been working directly with clients since 2019, the present study focuses on data from 341 cases over 16-months (March 1, 2021 through June 30, 2022) that were collected once a SURT records management system was established. Importantly, we were not able to access information on all overdose calls for service in the area during this period so we cannot establish a rate of overall referral but instead use all cases identified by the incident analyst and provide to the SURT peers as our denominator ($N = 341$) to look at the rate and duration of follow-up. Records management also includes a measure of contact hours which includes efforts to contact the person and follow-up peer support which encompass time spent identifying available treatment and waiting at appointments. All data were collected as part of routine practice and deidentified for analysis as part of a program evaluation and non-human participant research. Variables were coded from administrative data with descriptive and bivariate analysis (Chi-square and t-tests) conducted in SPSS (version 26; SPSS, Armok, NY).

Table 1
Client demographics, referral source, and follow-up engagement ($N = 341$).

	Mean	SD
Age (years)	35.85	11.26
Race-Ethnicity Categories	N	Percent
American Indian/Alaska Native	88	26.7%
Asian	1	0.3%
Black/African American	14	4.3%
Hispanic/Latino	2	0.6%
White/Caucasian	224	68.1%
Gender		
Female	128	37.5%
Male	213	62.5%
Referral Source		
Law enforcement first responder	149	43.7%
Criminal-legal agency	85	24.9%
Community stakeholder	26	7.6%
Self-referral	55	16.1%
Family or friend	26	7.6%
Engagement Type		
In-person contact	207	60.7%
No contact	134	39.3%
Any completed goals (n = 207)		
Yes	166	80.2%
No	41	19.8%

Notes: $N = 341$. March 1, 2021, through June 30, 2022. Age missing for 22 cases.

2. Results

During the 16-month study period, there were 341 unique referrals, an average of more than 20 per month. Nearly two-thirds (62.5%) were male, and the average age was 35.9 years. More than one-quarter were Indigenous or American Native persons (26.7%) and more than two-thirds were white (68.1%). Referrals came from a variety of sources with the most (43.7%) from law enforcement first responders, 24.9% from other criminal-legal agencies including courts and community supervision; and 16.1% through self-referral (Table 1).

In-person contact is the goal of the follow-up, and was accomplished with 60.7% of referrals (i.e., SURT had in-person contact with 207 of 341 persons who were identified as having had an overdose), of which 80.2% went on to complete an engagement goal with the peer specialist. There was an average of 2 engagement goals per client, which resulted from an average of 4.6 contact hours (SD=6.9), with assessments (34.8%) as the most common goal followed by treatment engagement (28.6%) and entry into a detox facility (19.0%) (Table 2). There was no significant variation in client demographics (age, race-ethnicity, gender), nor referral source or follow-up engagement (in-person or not); however, client referrals from law enforcement first responders at nonfatal overdose events are significantly less likely to result in an in-person contact (38.3% vs. 78.1%, $\chi 2 = 55.9$, Cramer's $V = 0.405$, $p<.001$) though,

Table 2
Follow-up engagement outcomes.

	Mean	SD
Number of goals completed	2.0	1.5
Number of contact hours	4.6	6.9
Goal category frequency	N	Percent
Assessment	117	34.8%
Education	2	0.6%
Employment	7	2.1%
Detox facility	64	19.0%
Enter/Start treatment	96	28.6%
Health care	6	1.8%
Housing	15	4.5%
Recovery supportive services	29	8.6%

Notes: March 1, 2021, through June 30, 2022.

if contact was made, are statistically similar in likelihood to complete an engagement goal than those from other referral sources (75.4% and 82.0%, respectively).

3. Discussion

In this short report we described and examined administrative records from a novel and innovative post-overdose follow-up response program led by peer recovery specialists who are embedded with the local city police department. Given that all of the published research to-date has focused on law enforcement led post-overdose follow-up, we present our findings as evidence of an alternative approach communities might consider. Peer recovery specialists are a paraprofessional workforce with an emerging evidence-base on the positive effects of incorporating these persons of lived experience as part of the recovery support process, particularly among those who are navigating criminal-legal systems involvement but also in overdose response efforts (Bardwell et al., 2018; Bartlett et al., 2011; Felton et al., 2023; Victor et al., 2021).

While there are documented barriers to hiring peer specialists, specifically because of prior involvement in criminal-legal systems, the SURT sees this experience as an advantage as it gives peer staff shared experience with the people they serve. Given that more than one-quarter of clients were American Indian/Alaskan Native, this same philosophy guided SURT in bringing on a Native American male to focus on identifying effective means of engagement within this shared cultural context. The SURT peer specialists have autonomy over their work and leverage their embeddedness in a criminal-legal system to build trust by helping clients to address outstanding warrants and avoid arrest, sometimes by engaging directly with community supervision and agents of the court, to mitigate negative legal consequences. Moreover, with employment as civilian staff within the police department, the peer specialists are provided a more competitive salary, along with benefits that come from being a city employee (e.g., pension), which can assist with recruiting diverse applicants, job retention, and long-term program sustainability.

The SURT peer specialists recognize the stages of behavior change (DiClemente, 1999) and much of their initial outreach is focused on developing rapport and determining needed areas of recovery support. They also provide a range of harm reduction support services including fentanyl testing strips, naloxone, new syringes, and infectious disease testing. From initial outreach through rapport building it is unlikely SURT would be as successful if police were present. It is difficult to compare given the variation in programs and study designs but existing research suggests police and EMS post overdose response programs respectively range from 54% (Formica et al., 2018) to 60% (Scharf et al., 2021) in terms of contact where SURT was able to achieve in-person contact with 60.7% of referrals, of which 80% engaged with peer specialists to complete a recovery-oriented goal. However, much further research is needed to assess program effectiveness and determine the rate of referral from all overdose calls for service in the study jurisdiction. Additionally, it is a notable finding that law enforcement referrals were less likely to result in an in-person contact, and while SURT peers would suggest it results from less appropriate or difficult to contact referrals (e.g., unsheltered persons who cannot be located in the community), future research should aim to understand which nonfatal overdose survivors are in greatest need and most appropriate for peer-led follow up services. The present study is also limited to the administrative data fields, which were not designed for research purposes; as such, a primary goal for future research should focus on developing a comparison group and assessing changes in treatment engagement, criminal-legal systems involvement, emergency medical events, and mortality following SURT. Additionally, contact hours does not capture the nuance in SURT activity but instead a measure of overall time spent with the client including contact efforts. Moreover, the data collection period started approximately one-year after COVID-19 stay-at-home orders in the state and so referrals and follow-up before or after might differ based on this factor. Despite the limitations, the findings offer an important contribution to the research literature by documenting outcomes from a novel-overdose response program of peer specialists who are embedded within a local law enforcement agency.

4. Conclusion

At a time when communities are questioning the role of police in the overdose epidemic, it is important to note that unannounced follow-up from law enforcement might be exacerbating overdose-related harms. Even well-intentioned officers might induce fear and trauma among overdose survivors and their family. Yet, nonfatal overdose does provide a critical opportunity to link people with health systems and social supports. The model described in this report is not driven by a law enforcement agency, but is facilitated through it, and run by persons with lived experience in recovery. The findings here suggest that this post-overdose response program is successful at locating and engaging community members who have had an overdose into recovery support services.

Contributors

Bradley Ray, Jessica McCarthy-Nickila, Nicholas Richardson, and Jeffrey Maahs. BR conceived of manuscript and wrote initial draft and incorporated feedback from JMN, NR, and JM. JM developed program data collection, JMN oversaw program and reviewed for accuracy of description, NR assisted with analysis and literature review. All authors contributed to the final written manuscript.

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Declaration of Competing Interest

No authors have any conflicts to declare but note that McCarthy-Nickila (co-author) was employed by the Duluth Police Department and oversaw program activities during the reported study period.

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SAMHSA ADVISORY
Substance Abuse and Mental Health Services Administration

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PEER SUPPORT SERVICES IN CRISIS CARE

Peer support workers—also known as peers—are individuals with **lived experience** who have sustained **recovery** from a mental or substance use disorder, or both.[1] They assist others entering or in recovery with reducing the **recurrence of symptoms**, more commonly known as relapse.[2-4] Peers model recovery, promote shared understanding, focus on strengths, offer positive coping strategies, and provide information and resources.[1]

Peers may engage in a range of non-clinical activities to support individuals or families of individuals in or seeking recovery from a substance use disorder, mental illness, or both. Activities may include mentoring, advocating for people in recovery, leading recovery groups, and building relationships.[1] These activities supplement other services an individual may receive. The role of the peer is unique in that it is based on the concept of **mutuality**—or sharing similar experiences. Peers offer a non-hierarchical relationship that differs from individuals' relationships with clinicians. Peers enhance the work of an individual's clinical care team and support them and their families as they navigate recovery.[2, 4]

Peer support workers are individuals with **lived experience** and may be called **peer support workers**, **peer specialists**, **peer recovery coaches**, **peer advocates**, **peer recovery support specialists**, or, collectively, **"peers"** who have undergone special training or certification to be effective in this role.

Peer support...

... is an evidence-based practice.
... has extensive literature to support the inclusion of peers in the behavioral health workforce.

Research on peer support has demonstrated...

... cost effectiveness.
... improved outcomes for recipients.

Improved outcomes for recipients include...[2-3]

... reduced re-hospitalizations.
... lower overall costs of services.
... increased service utilization.
... increased treatment engagement.
... improved quality of life.
... increased functioning.
... decreased behavioral health symptoms.

Key Messages

- Peer support services are an integral component of the behavioral health continuum of care—from prevention and early intervention to treatment, recovery, and crisis services.
- Crisis care provides services to anyone, anywhere, at any time. Three essential elements comprise crisis care: crisis phone lines, mobile crisis teams, and crisis receiving and stabilization facilities.
- There are several benefits to including peers in crisis care, including strengthening engagement in treatment and improving outcomes for individuals experiencing a crisis who receive these services.
- Peers working in crisis service care settings provide opportunities for individuals in crisis to talk with someone who has similar experiences, embodies recovery, and can offer messages of encouragement and hope.
- Peers may experience challenges related to role integrity, stigma from co-workers, and sustainable employment. They also face challenges unique to providing crisis care, including the complexity of managing crisis situations and, often, a lack of specialized crisis training.

Definitions

Behavioral health:[5] A key part of a person's overall health, which includes emotional, psychological, and social well-being, and that is just as important as physical health. Conditions that may impact behavioral health include mental illnesses, substance use disorders, and co-occurring mental and substance use disorders.

Behavioral health continuum of care:[6] An integrated system of care with varying levels of service intensity and settings in response to an individual's behavioral health needs.

Crisis care:[7] A range of services for individuals experiencing an acute mental and/or substance use disorder crisis.

Crisis respite:[7] Short-term, residential facilities that offer a restful, step-down environment with supports for individuals experiencing a crisis.

Lived experience:[2] Personal knowledge gained through direct, first-hand involvement.

Mutuality:[2] A positive, interactive relationship between people based on shared lived experience.

Peer drift:[8] When the role of the peer support worker begins to deviate from the practices that distinguish peer support workers from clinical providers or other recovery supports.

Peer support services:[2] Peer support services encompass a range of activities and interactions between people who share similar experiences of being diagnosed with mental health conditions, substance use disorders, or both.

Peer support workers:[1] People who have been successful in the recovery process who help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support workers help people enter and stay engaged in the recovery process and reduce the likelihood of relapse. Peer support workers are trained as recovery coaches or peer specialists and may include family peer supporters.

Recovery:[9] A process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential. The four dimensions that support recovery are health, housing, purpose, and community.

Recovery capital:[10] The internal and external resources that are available to individuals to initiate and sustain recovery from mental and/or substance use disorders.

Recovery support services:[9] A range of non-clinical support services designed to help people with mental and substance use disorders manage their conditions successfully.

Recurrence of symptoms:[11] A phase of recovery where a person's symptoms have returned and their functioning has decreased. This may be more commonly referred to as "relapse."

Strengths-based:[12] An approach to assessment and care that emphasizes the strengths of the individual.

Trauma-informed:[13] Services or care based on the knowledge and understanding of trauma and its far-reaching implications.

Warm line:[7] A phone line individuals can call to receive services that are less intensive than what one would receive when calling a hot line, like opportunities for talking, support, and referrals to other services.

Peers may be paid or unpaid and work in a range of settings. These settings include peer-run organizations; behavioral health centers; certified community behavioral health clinics; inpatient, residential, and outpatient programs; primary care; criminal justice settings; homeless shelters; child welfare agencies; educational settings; and emergency departments.[2, 14]

Models of Peer Support Services

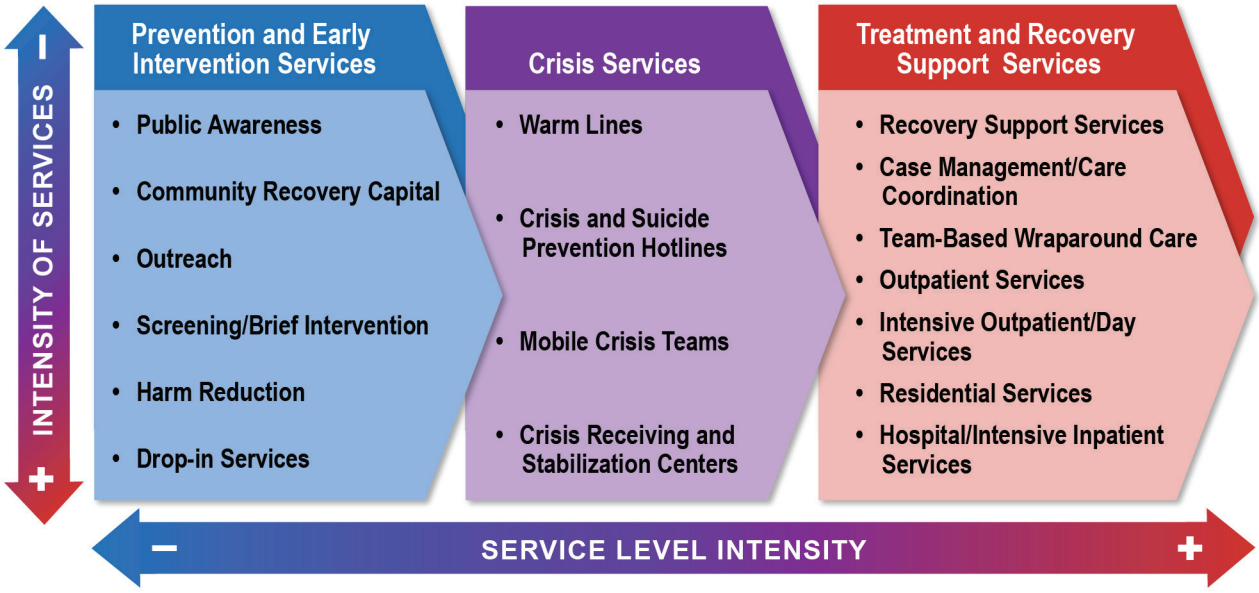
Recovery from a mental and/or substance use disorder—common conditions that affect **behavioral health**—is a process of change. The recovery process varies by person, based on social and contextual factors specific to the individual[15-16] as well as where the individual is on the **behavioral health continuum of care** (Figure 1). The continuum of care encompasses a full range of services. It can support the needs of an individual with a mental and/or substance use disorder with preventive and early intervention care, **recovery support services**, **crisis care**, and more intensive outpatient or inpatient treatment, if needed. With effective recovery support, individuals work with peers, clinicians, and others to identify the services that can help to achieve and maintain their own recovery.

Individuals may receive **peer support services** along the full continuum of care through a variety of roles and service models. These models, as well as the roles and responsibilities of peers within them, vary depending on the organization and setting. The three broad organizational structures that typically deliver peer support services include:

- *Peer-run* organizations may also be referred to as freestanding organizations and are operated and staffed by peers; these include drop-in centers and recovery community organizations.
- *Integrated* organizations may also be referred to as embedded organizations and are traditional behavioral healthcare systems that offer a range of services, including counseling, and hire peer support workers.
- *Hybrid* structures offer a combination of the previous two and are organizations that contract with a peer-run organization for peer support services.

Some medical settings (e.g., primary care and emergency departments), human services, and other programs and settings (e.g., housing programs, mental health and/or drug courts, school systems, and faith-based organizations) may also provide peer support services.

Figure 1. Key Components of a Behavioral Health Continuum of Care



Crisis Care

Individuals may experience a crisis or a situation causing significant emotional distress. Many of these individuals, but not all, may have a mental and/or substance use disorder. Crises differ for each individual and may result from adverse changes in life circumstances, such as the loss of a relationship, loved one, or job, or they may represent the worsening of untreated mental or substance use disorder. Crises may happen any time or anywhere and can have devastating impacts on individuals, families, and communities.[7] Some individuals may be at risk of harming themselves or, less likely, others, unable to care for one's self or access basic needs like food and shelter, or experience other problems related to substance use and mental illness.[17]

Crisis Care in Action: Georgia Department of Behavioral Health and Developmental Disabilities

Certified peer specialists are included in all levels of the state's emerging crisis system, including the Georgia Crisis and Access Line, mobile crisis response service, and the treatment teams at crisis stabilization units and behavioral health crisis centers. Peer specialists provide support through text/chat, taking initial calls, dispatching mobile crisis units, and face-to-face rapid response.

Crisis care encompasses a range of services that help individuals better manage current circumstances.[17] Crisis care may also involve treating physical concerns related to substance use, withdrawal, or sub-acute chronic poor health. The purpose of crisis care is to support the individual, engage them in the least restrictive services, and avoid unnecessary hospitalizations or arrest.

Elements of a comprehensive crisis care system ideally include the following:[7]

- *Crisis lines* that operate 24 hours a day, 7 days a week and are staffed with clinical and peer staff who can provide crisis intervention capabilities, meet National Suicide Prevention Lifeline standards for risk assessment and engagement of individuals at imminent risk of suicide, offer quality coordination of crisis care, and accept all calls and dispatch support based on the assessed need of the caller.
- *Mobile crisis teams* that can be dispatched to wherever the need is in the community, such as a person's home or workplace, in a timely manner.
- *Crisis receiving and stabilization facilities* that provide short-term observation and stabilization in a non-hospital environment for all individuals, regardless of referral source.

Additional elements of comprehensive crisis care may include short-term crisis residential services, **warm lines**, and psychiatric advance directive statements.[17] Comprehensive crisis care also provides individuals with referrals or direct linkage to needed medical or behavioral health services or other follow-up care. These elements combined provide individuals experiencing a crisis with someone to call, someone to respond, and somewhere safe to go.

Originally, crisis care was a concept developed from a mental health perspective. However, it has evolved into a model that is available community-wide, providing services that can meet the needs of anyone, anywhere in the community, and at any time the crisis is occurring. Crisis care systems are not reserved for those with a particular known diagnosis or treatment history. Therefore, those who work in crisis care should be able to provide services to individuals with a range of conditions or circumstances, assess and manage the situation, and connect individuals to viable treatment, recovery, and other resources that are culturally effective and meet their needs and preferences. Resources and training on providing culturally and linguistically appropriate services can be found in the Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care.

Currently, the elements essential to crisis care are not universally available, and there are few communities in the United States with a comprehensive crisis response system in place.[19] Additionally, increased demand is expected for crisis services with the transition to 988, the new, three-digit dialing code that will connect individuals in crisis to counselors, in July 2022. As a result, individuals may receive fragmented services in systems not designed to deliver effective crisis care.[19] A comprehensive continuum of crisis care will help reduce the adverse impacts too often seen with current crisis management, such as arrests or forced hospitalizations, that can result in additional trauma to the individual.[20] Such a continuum can also help improve the quality of care and likelihood of successful outcomes.[7] Communities should emphasize the development of these services to provide safe, effective, and respectful management for individuals in crisis and reduce avoidable arrests and incarceration, emergency department visits, psychiatric hospitalization, involuntary commitment, physical restraint, and other negative experiences.

Crisis situations may also negatively impact an individual's family and caregivers. It is important that they, too, are educated about self-care and how to best provide support to their loved ones. Addressing the needs of families and caregivers is a critical component of stabilizing the individual in crisis and can help reduce the possibility of subsequent crisis situations.[7] Peer support services are also available for parents, families, and other caregivers of individuals who experience a crisis. These peers provide expertise and support based on their own experiences in individual and group settings and may provide information and education, and help navigate systems of care more efficiently.[18]

What Can a Crisis Look Like?

An individual experiencing a mental health crisis may withdraw from family and friends, have dramatic shifts in mood, exhibit unpredictable behavior that results in law enforcement encounters, increase their substance use, struggle to fulfill obligations or maintain self-care, or experience paranoia and hallucinations that result in an emotional breakdown or suicidal thoughts or attempts.

An individual experiencing a substance use-related crisis may have similar experiences, culminating in acute intoxication, withdrawal symptoms, encounters with law enforcement, or overdose.

Because the behaviors are similar, it may be difficult to distinguish between a mental health crisis and a substance use-related crisis. Many individuals also experience co-occurring disorders—meaning they are diagnosed with both a mental and substance use disorder. As a result, it is rare that an individual needing crisis care will only require services to address one of these conditions. Oftentimes, substance use may exacerbate an individual's mental health symptoms; likewise, changes in mental health may lead to increased substance use.

Peer Support Services Within Crisis Care

Peer support services complement clinical services and help individuals in crisis. Some peer support workers specialize in providing services during a crisis, while others without specialized training may assist during a crisis if requested or as needed. Peer support workers who provide services to individuals experiencing a crisis may do so within various organizational structures.

Peer support workers can establish valuable rapport, share common experiences, strengthen engagement in care, and engage with family members or others close to the individual on how to best support them.[7] The inclusion of peer support workers in crisis care also helps facilitate a **trauma-informed** response and recovery-oriented and **strengths-based** approaches. Peer support workers demonstrate that recovery is possible and act as an advocate for the individual. This may help improve outcomes, such as reduced trauma and agitation, increased trust, reduced hospitalizations and emergency department usage for mental and/or substance use disorders, reduced recurrence of symptoms, and decreased recidivism.[20]

Although peer support workers provide services throughout the crisis continuum of care, they are often found as part of a mobile crisis team or within stabilization facilities. The purpose of both is to de-escalate the crisis, address needed care, and stabilize the individual; however, there are some key differences between the two. Mobile crisis teams provide care wherever the individual is in the community and will connect or transport them to the appropriate setting for further assessment and care.[21] Stabilization facilities provide care in a static location and offer an environment less restrictive than hospitalization; depending on the location, individuals may be able to "walk-in" for services.

The level of crisis care depends on the intensity of the crisis an individual is experiencing. Peer support workers may be involved with crisis care at any point and facilitate interventions at the most appropriate level. As depicted in Figure 2, settings and peer support services are different depending on the intensity of the crisis and the level of care needed to support the individual.

Peer support workers may provide crisis and other services to individuals virtually. Virtual peer support services may include individual outreach, support groups, scheduled visits, or post-crisis follow-up services. Virtual peer support services may also be a component of crisis response where the peer support worker can help to de-escalate the crisis, provide support during assessment, and connect the individual to resources remotely.[22]

The Evidence Base for Peer Support Services in Crisis Care

Preliminary research suggests that the use of peer support services in emergency departments for individuals experiencing a mental and/or substance use disorder crisis adds value to clinical services, decreases adverse outcomes secondary to the crisis, and increases communication and collaboration.[23]

Evidence suggests that including peer workers on mobile crisis teams reduces subsequent use of crisis and emergency services.[24]

Warm lines staffed with peer support workers can fill a void in services and assist with symptom management and the recovery process, particularly when operating after hours and overnight, when other crisis services are typically unavailable.[25]

The Role of Peer Support in Crisis Care

Peer support workers can provide valuable services. Their key functions in crisis care include:

- *Crisis prevention*. Peer support workers can provide interventions, such as outreach and recovery support, which can prevent crisis, especially during times of stress. The peer can promote engagement with community supports that the individual has found helpful in the past, such as family, friends, treatment providers, housing, or other social services.

Figure 2. Peer Support Services and Settings for Crisis Care by Intensity of Need

	Pre-Crisis Care	Sub-Acute Care	Acute Care	Stabilization	Post-Crisis Care
Purpose	• Services intended to avert a crisis, or, if a crisis occurs, alleviate the need for more acute services.	• Services provided to those who experience a mental and/or substance use disorder crisis, but do not require acute care.	• Services provided to de-escalate a crisis and/or when acute behavioral health care is required.	• Services designed to assist with symptom stabilization before returning to the community.	• Services aimed to support the individual after the crisis has subsided.
Settings	• Peer-run organizations, such as recovery community organizations and drop-in centers. • Mobile recovery centers. • Outpatient and rehabilitation programs. • Homeless outreach.	• 23-hour stabilization units and beds. • Inpatient hospitals and partial hospitalization programs. • Hospital diversion houses.	• Emergency departments. • Mobile crisis teams. • Crisis intervention and response teams. • Police and correctional diversion.	• Crisis receiving and stabilization units and facilities. • **Crisis respite**. • Recovery residences. • Living rooms.	• Peer-run organizations, such as recovery community organizations and drop-in centers. • Assertive community treatment teams. • Other outpatient and rehabilitative support settings.
Services	• Outreach. • Warm lines. • Crisis planning. • Linkage to resources. • Individual and group digital support. • Harm reduction.	• In-patient and partial hospitalization care and advocacy. • Short-term crisis residential services. • Short-term intensive treatment and services. • Linkage to resources.	• Crisis hotlines. • Emergency department care and advocacy. • Intensive treatment and services. • Linkage to resources.	• Residential stabilization. • Step-down services. • One-on-one support. • Linkage to resources.	• Post-crisis support groups. • Recovery supports. • Social inclusion and structure. • In-home peer companionship. • Self-care supports. • Digital support.

Peer support workers may provide peer support services to individuals experiencing a crisis, engage in other components of crisis care (e.g., educational activities like providing crisis intervention team training for first responders), and teach QPR (question, persuade, refer) for suicide prevention.[20]

- *Crisis management*. Peer support workers who provide crisis care through warm lines, hotlines, mobile crisis teams, and other services can help individuals by de-escalating the crisis, conducting non-clinical assessment services and interventions, and providing advocacy and support.
- *Crisis resolution and follow along*. After responding to the crisis and engaging the individual in care, peer support workers can help address the underlying factors that contributed to the situation. This may include helping the individual manage symptoms, navigate ongoing treatment and care, and transition to ongoing services within the community. Peer support workers may also engage with families and provide them with resources to meet the needs of the individual in crisis. Peers are essential in promoting person-centered recovery supports that help individuals avoid future crises.

Of these functions, the role of the peer support worker is of particular importance in crisis response. Peer support workers who are onsite at a crisis, or who are available where the individual is brought after a crisis, can play a crucial role in guiding an individual's next steps for care. For example, individuals who are brought to the emergency department after an overdose may be monitored and released; however, emergency departments staffed with peer support workers can facilitate the connection of these individuals to available treatment and recovery resources that they otherwise may not receive.

Crisis Care in Action: People USA

People USA operates four peer respites, two peer-led mobile teams, and a peer-run crisis stabilization center, and offers a host of peer services throughout New York State. Staff receive training that is specifically for handing crisis situations; for example, all staff are trained in suicide intervention. Peers support individuals using empathy, engagement, and open dialogue to help de-escalate the situation and devise a plan for treatment or other support needed moving forward, such as linkage to additional resources.

The Role of Peer Support in Recovery

Mental and substance use disorders are chronic brain diseases with the potential for recurrence and recovery. Peer support services are grounded in strengths-based practices essential to recovery. Some individuals will experience the recurrence of symptoms. However, the recovery process can begin again in the event of symptom recurrence.

Individuals who receive peer support services during a crisis will likely also encounter peer support workers in roles other than crisis care as they begin and continue through the recovery process. A peer support worker may work through a crisis with an individual as part of a mobile crisis team, and subsequently be referred to a peer-run organization to receive additional post-crisis support services.

Recovery and improved health and well-being are the goals of behavioral health care for individuals with a mental and/or substance use disorder. Experiencing a crisis may be a catalyst for individuals to engage in behavioral health services they had not previously been involved with and that are important for initiating and sustaining recovery. Because a mental and/or substance use disorder crisis often results from

environmental challenges and events, such as trauma, job loss, financial or relationship troubles, or other interpersonal stressors, addressing these real-life issues is crucial to sustaining recovery.

The recovery process looks different for everyone and is a highly personalized process. Individuals may engage with a variety of services along the behavioral health continuum of care. Regardless of trajectory, the following principles guide the recovery process and the activities of peer support workers:[26]

- Recovery emerges from hope.
- Recovery is person-driven.
- Recovery occurs via many pathways.
- Recovery is holistic.
- Recovery is supported by peers and allies.
- Recovery is supported through relationships and social networks.
- Recovery is culturally based and influenced.
- Recovery is supported by addressing trauma.
- Recovery involves individual, family, and community strengths and responsibility.
- Recovery is based on respect.

Crisis Care in Action: Recovery Innovations (RI) International

Recovery Innovations International/RI has 18 crisis centers across seven states. The crisis centers integrate peer support specialists alongside a clinical team member to create a trauma-informed, recovery-focused environment. These crisis centers include recovery response centers (crisis stabilization programs), evaluation and treatment centers (involuntary and court-ordered treatment) and crisis respites. The centers are aligned with the Crisis Now model for exceptional practices for crisis stabilization programs.

Considerations for Peer Support Services in Crisis Care

Protecting role integrity for the peer support worker is an important consideration in crisis care. Role confusion and ambiguity around the duties and functions of peer support workers is common and may lead to **peer drift**. The role of peer support workers can "drift" in different directions depending on organizational and individual situations, circumstances, and culture. Peer drift may result in peer support workers not being considered a legitimate part of the support team and can inadvertently cause insecurity around one's role as a peer support worker.[27]

The two broad categories of peer drift include:

1. *Organizational peer drift*. Organizational peer drift often occurs when non-peer colleagues marginalize peer support workers, which can result in assigning tasks that misalign with their dedicated duties and responsibilities. This form of peer drift may occur if non-peer staff are not familiar with the role, code of ethics, and scope of practice of peer support workers under their state certification, as applicable. As a result, clinical staff or other colleagues may not regard the peer support workers as individuals with meaningful knowledge and resources and give them tasks that conflict with their purpose. In these situations, clinical colleagues may ask peer support workers to handle medications, oversee urine drug screens, transport individuals, answer the phone, or be involved with involuntary treatment. They may also be asked to do tasks for which they are not qualified, such as those associated with formal treatment, or may become more clinical in nature if they are required to conduct such services.

2. *Individual peer drift*. Individual peer drift is when the peer support worker acts in a role that differs from that which is intended. This form of peer drift may occur when peer support workers' tasks inadvertently take on characteristics of their colleagues (drifting towards a clinical role) or are perceived as a form of other support by the individuals with whom they work (drifting towards an informal or casual role). For example, because peer support services are rooted in the concept of mutuality and voluntary support, boundary issues may arise between peer support workers and those they support. Over time, this relationship may become less structured and more casual, which can cause the individual they are working with to view them as a sponsor, friend, or informal therapist. Similarly, peer support workers who work in traditional behavioral health care or medically oriented settings may adopt a more clinical approach to service provision through the practices of their clinical colleagues.

Individual Peer Drift and the Role of Peer Support Workers

Peer support workers who work in traditional behavioral health care or medically oriented settings may be more susceptible to drift towards clinical roles because of the environment in which they work.[8] However, peer support workers may also drift towards less formal roles. Programs can avoid both forms of individual peer drift by setting and maintaining healthy boundaries and implementing a clearly defined code of ethics.

What Peer Support Workers Should Do	What Peer Support Workers Should NOT Do
• Serve as a role model. • Provide support during a crisis. • Help with goal setting and wellness planning. • Make connections with other services and supports.	• Perform work that does not meaningfully contribute to care. • Act as a sponsor, therapist, or clinician. • Assess, diagnose, or treat an individual. • Assimilate into other roles.

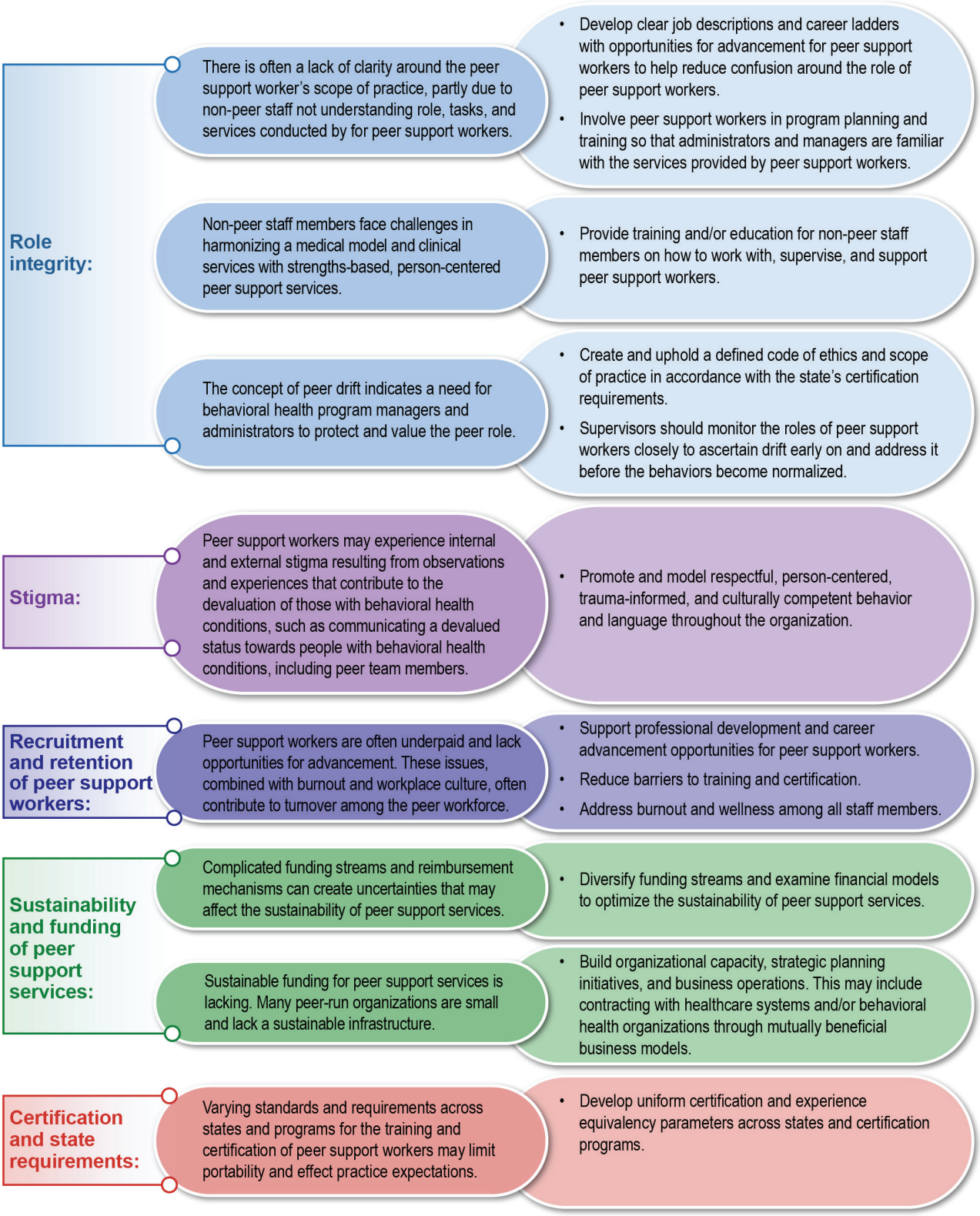
Peer support workers who provide crisis care may be especially vulnerable to peer drift, as they often work alongside clinicians or others in non-peer roles. For example, colleagues of peer support workers in crisis care may ask them to influence an individual experiencing a crisis towards behaviors or decisions that others feel are best, such as agreeing to a treatment option they do not want. Peer support workers who experience these situations may have decreased job satisfaction, contributing to issues with workforce retention.

To avoid peer drift, peer support workers who provide crisis care should have a defined role that reflects the setting in which they work and the services they provide. They should also work with and be supervised by staff who are familiar with the peer support role and the services they provide. Staff responsible for supervising peer support workers should meet the necessary experience and training requirements to ensure successful integration of the peer role and promote and the appropriate utilization of peer support workers within the organization.

Additional resources on the supervision of peer support workers can be found in the Resources section. Figure 3 lists additional considerations for peer support workers. All considerations presented may be compounded by challenges unique to providing crisis care, including the following:

- Crisis situations can be tense and complicated to manage. In addition, crisis situations may trigger distress in peer support workers and others responding to the crisis because of past trauma they themselves experienced.

Figure 3. Key Considerations, Issues, and Potential Solutions for Peer Support Services



- Individuals experiencing a crisis should be able to freely choose the services they receive. Those responding to a crisis, including non-peers and peer support workers, should not coerce individuals to participate in services, and non-peers should not request peer support workers to use their relationship to influence an individual's decisions.
- Peer support workers may be asked to provide crisis care if others are not available to assist in a crisis, even when they do not have specialized training in this area.
- Peer support workers may be asked to provide crisis care to individuals or populations with whom they have not been trained to work, such as those with intellectual or developmental disabilities. Therefore, they must be familiar with the resources available to all populations in the community, not only those specific to mental and substance use-related disorders.
- Peer support workers who provide crisis care should be familiar with mental and/or substance use disorder crises and act as advocates for the individuals with whom they are working.

Crisis Care in Action: SHARE! Culver City

SHARE! Culver City is a peer-run center located in southern California that receives approximately 5,000 visits a month. SHARE! offers a range of services including residential treatment, and always has at least two peer specialists available during each shift in case an emergency or crisis occurs. In such an event, the peer specialists will work with the individual to de-escalate and assess the situation and determine if additional services are needed.

Tips for Optimizing Peer Support in Crisis Care

The following tips can help behavioral health program managers and administrators, hospitals, other clinical programs, and peer support workers optimize peer support services in the delivery of crisis care.

For Healthcare Administrators, Leaders, and Organizational Staff

- Identify sustainable funding sources for peer support programs.
- Hire peer support workers familiar with a recovery-focused model of practice.
- Integrate peer support workers into the employee structure and solicit peer input on program activities and training.
- Ensure peer support workers are supervised well and assess for peer drift. Staff who supervise peer support workers should be well-trained and prepared to uphold the principles of peer support services for all staff members.
- Develop a training program for peer support workers and clinical or other staff that educates them on what peer support services are and how staff can incorporate them into the organization.
- Encourage clinical or other staff to learn about and observe the role of the peer support worker by auditing certification classes or visiting drop-in centers.
- Address negative staff attitudes around hiring peer support workers, such as bias towards individuals with a mental and/or substance use disorder. This includes upholding expectations for staff language and conduct to prevent discrimination that may result from an individual's lived experience.

- Recognize the common considerations noted previously when integrating peer support services in crisis care, including addressing the need for staff training, particularly for clinicians and non-peer staff; incorporating the use of collaborative tools; and conducting continuous quality assessment and improvement.

For Peer Support Workers

- Engage in self-care to maintain personal well-being and to model similar behaviors for the individuals with whom they are working. This is especially important given the rate of burnout and risk of symptom recurrence among peer support workers.
- Understand crisis management and how to identify and safely manage a crisis. Peer support workers may encounter individuals experiencing a crisis during their normal work. They should be familiar with the components of crisis response, such as how to activate a crisis intervention, help de-escalate the crisis, and connect individuals with crisis care.

Resources

Name	Description
Crisis Resources	
National Guidelines for Behavioral Health Crisis Care	Guidelines designed to assist states and communities with the development and implementation of effective crisis services and systems.
Crisis Services: Meeting Needs, Saving Lives	SAMHSA's "National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit" and related information on crisis services.
Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies	An assessment of the clinical and cost effectiveness of crisis services, as well as approaches states are using to coordinate, consolidate, and fund robust crisis services.
Hospital Diversion Services	A manual to help guide the local development of respite/ hospital diversion services.
Tip 59: Improving Cultural Competence	A guide for providers and administrators on the role of culture in the delivery of mental health and substance use services, including cultural competence and racial, ethnic, and cultural considerations.
Peer Workforce Resources	
Peer Support Toolkit	Key information for specific implementation issues relevant to agencies in various stages of integrating peer support services.
Core Competencies for Peer Workers in Behavioral Health Services	SAMHSA's core competencies for peer workers in behavioral health, which are informed by research and best practices.
National Practice Guidelines for Peer Specialists and Supervisors	Practice guidelines that include specific guidance for supervisors and offer expertise and practical guidance.
Peer Specialist Training and Certification Programs	A state-by-state guide on peer training and certification programs, credentialing requirements, billing, and other relevant information.
Sample Job Description for Peer Support Positions	A comprehensive template that organizations can use when developing job descriptions for peer support workers. This template includes details about major job duties and responsibilities, knowledge necessary for the position, the work environment, and the scope of the role.
Supervision of Peer Workers	A brief resource to help supervisors understand how to supervise peer workers in behavioral health services.
Guidelines for the Supervision of Peer Workers	A comprehensive list of resources on peer support practices, best practices in supervision, and recovery-oriented services.
Avoiding Peer Support Drift: Maintaining Your Role as a Change Agent	A presentation explaining peer drift and how to avoid it.

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SAMHSA ADVISORY

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https://starexponent.com/news/local/our-community-puts-its-trust-in-us-rrcs-is-large-business-of-the-year/article_2ccb2a76-608b-11ed-9af6-af317a3ce326.html

ALERT TOP STORY

CHAMBER OF COMMERCE AWARDS

'Our community puts its trust in us'—RRCS is Large Business of the Year

Richard Horner
Dec 4, 2022

Executive Director Jim LaGraffe (left) and Board Chair Eve Brookes accept the Large Business of the Year Award from the Culpeper Chamber of C
Richard Horner

Richard Horner

Rappahannock-Rapidan Community Services capped off its 50th anniversary year with an award for Large Business of the Year from the Culpeper County Chamber of Commerce.

The organization was honored with the recognition at the 108th Annual Meeting and Awards Banquet held Nov. 3. This was the first chamber award received by RRCS since its founding in 1972.

“We are thrilled! It truly validates the importance of RRCS but more importantly it recognizes the role and impact that each of our 400 employees has within our community,” said RRCS Executive Director Jim LaGraffe.

“We are also proud of our ripple effect: when someone reaches out to RRCS, both they–and those they know, are impacted by the support they receive.”

LaGraffe attributed the organization’s recognition to several aspects of growth over the past several years.

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This includes agency’s ongoing, proactive approach and demonstrated commitment to the values of diversity, equity, inclusion and belonging instilled in all 400 employees across its service areas and agency operations, he said.

RRCS has also shown financial budget growth of 23% in recent years, enabling it to continually meet or exceed demand for services in a variety of areas. Those areas include aging, children, intellectual and developmental disabilities, behavioral health, substance use disorders, crisis services, suicide prevention, case management and elder housing.

The organization serves over 10,000 people annually in a planning district that includes Culpeper, Fauquier, Madison, Orange and Rappahannock Counties.

Another of the agency’s newer services is the S.E.E. Recovery Center, which stands for support, encourage and empower. According to LaGraffe, the center provides a barrier and stigma-free entry point for substance use and behavioral health services. It also provides outreach programs and other resources for older adults to minimize social isolation and depression, and assist with affordable housing opportunities in the area.

RRCS also began a commitment to area students in 2022 with the launch of an academic scholarship program. Annual awards will given of $5,000 to $10,000 for undergraduate students up to $15,000 for graduate students pursuing a degree in Human Services. This includes areas such as psychology, sociology and social work.

LaGraffe also expressed pride in the organization's ability to remain adaptable during the coronavirus pandemic.

"We had no layoffs, furloughs or reduction of hours during this time for any of our staff. By ensuring our staff were well taken care of, they were free to devote their energy to supporting members of our community who needed them most," said LaGraffe.

RRCS had either met or exceeded the increased demand for support and services due to the pandemic, the organization's chief's said. It succeeded in this by being creative and flexible with the support it offered.

"If it wasn't safe for people to come to us, we went to them. We dramatically expanded the use of technology to reach people who were otherwise isolated. Our staff did what was needed and always put the needs of our community ahead of their own," LaGraffe said.

Plans to further expand the organization's services are in the works as well as a new strategic plan that will carry RRCS into the next several years, he said.

Goals include increased access to services, increasing awareness of available services and developing increased capacity to respond to the changing needs of the community.

"During the past 50 years we have never sat still as an organization. Today, we continue to look forward to ensuring all the members of our community who need us get the support they need," said LaGraffe.

"Our community puts its trust in us, and we will work hard everyday to ensure that trust is deserved."

To learn more about RRCS,
visit **https://www.loc8nearme.com/virginia/culpeper/rappahannock-rapidan-community-services/7012194/**

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https://dailyprogress.com/community/orangenews/news/rrcsb-adds-peer-recovery-program-to-services/article_5462844e-08d1-11eb-a1e9-97f5628767af.html

RRCSB adds peer recovery program to services

Becca Pizmoht

Oct 8, 2020

In the past decade, peer recovery programs have gained popularity in the treatment of substance abuse problems. Clinicians have recognized the success of groups like Alcoholics Anonymous and Narcotics Anonymous and with peer recovery programs have begun to utilize the positive aspects of peer support and life experience to help patients.

Peer recovery support is used by non-clinicians as part of a program to help recovering addicts make changes that help with their overall recovery. Often addicts engage in patterns of lies and deception to minimize the ramifications of their substance use and while doctors and mental health professionals play an important part in recovery, peer support often can provide an added benefit. Peer recovery programs depend on recovered addicts to provide guidance and support for those new to the rehab process.

As well-intentioned as many doctors and psychologists may be, they often lack personal experience in dealing with some aspects of addiction, including the legal system. Intervention and support for the recovering addict makes a difference in the success or failure of the treatment. Peer recovery specialists provide wellness-focused and trauma-informed support fitting an individual's needs and choice.

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Earlier this year, the Rappahannock Rapidan Community Services Board (RRCSB) added peer recovery programs to the list of services offered to local residents.

RRCSB offers the services for free to any residents of the five-county (Culpeper, Fauquier, Orange, Madison and Rappahannock) area who are 18 or over and dealing with a diagnosed substance use disorder or a mental health issue. The services are individually tailored to every person's specific need.

RRCSB Executive Director Jim La Graffe sees the program as a plus for the community.

“Being able to talk to a peer [about addiction] is often an entryway to treatment,” La Graffe said. “There really is no downside to this.”

Cory Will is the director of the new program and is enthusiastic about the opportunities the new program offers for helping recovering addicts. Will said the program has evolved at a critical time as the coronavirus crisis has increased stress among the vulnerable and eliminated some traditional opportunities for treatment.

“With the pandemic we’ve been forced to do more virtual meetings and traditional groups like AA have become homeless,” said Will. “Some people in our region don’t have access to internet or they’re not comfortable with it. Churches and schools, the places where these groups meet, have been reluctant to hold public gatherings. Some have tried to hold meetings in parking lots and outdoor spaces. At a time when we need more services, resources have been stretched.”

Will believes that the program is effective because recovering addicts are often more receptive to the advice of someone with a similar history.

“Sometimes a suggestion that comes from a clinician is met with resistance. It’s a lot harder to ignore the same advice coming from someone that has been there before. There’s a lot more believability when it comes from someone that has been in your shoes,” Will noted. “It allows the recovering addict to see the possibility that they too can get through it.”

Madison County Director of Social Services believes the shared experiences help form a unique connection that can help aid in a patient’s recovery.

“Dealing with addiction there is not a one size fits all approach,” Madison County Director of Social Services Valerie Ward said. “Particularly with cases involving custody it really helps for the recovering addict to have someone who understands what they are going through. It shows them the possibility that the system isn’t set up for them to fail.”

For more information on peer recovery services, visit RRCSB at **www.rrcsb.org** or call (540) 825-3100 in non-emergency situations. Call (540) 825-5656 in an emergency mental health or substance abuse situation.

https://starexponent.com/lifestyles/health-med-fit/spanberger-tours-recovery-centers-in-culpeper/article_58c28096-0346-5320-bb1d-1648fca7ce8d.html

ALERT TOP STORY

Spanberger tours recovery centers in Culpeper

Allison Brophy Champion
Jan 29, 2022

Rep. Abigail Spanberger eyes items included in a harm-reduction kit being distributed in five Culpeper-area counties through Rappahannock-Ra Services. It includes Narcan and fetanyl test trips, explains Cory Will (right), peer-recovery program manager at Culpeper's new S.E.E. Center.
photos by ALLISON BROPHY CHAMPION/CULPEPER STAR-EXPONENT

Allison Brophy Champion

Culpeper-area Community Services administrators, hosting U.S. Rep. Abigail Spanberger on Thursday, showcased a new local clinic that aids people needing immediate help with substance-use disorder and mental-health needs.

The 7th Congressional District lawmaker was clearly impressed with the evidence-based, living-room-style, drop-in site next to Culpeper National Cemetery's Old Section.

The S.E.E. Recovery Center, beside the Senior Nutrition Site on U.S. Avenue, opened less than six months ago. Already, it has assisted more than 6,000 people looking for various levels of help, guidance or a sympathetic ear.

“It’s a peer-led center, so everything is run by somebody with shared experience,” peer recovery specialist Cory Will, the center’s manager, told Spanberger on her second stop of the day touring local recovery centers. “Everybody in the building right now is in recovery for something.”

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A former Marine, Will is in recovery from post-traumatic stress disorder and a traumatic brain injury.

A facility like the S.E.E. center—where they “Support, Encourage, Empower” (hence its name)—has been needed for a while in the area as local overdoses continue to climb and people’s mental health is taxed by the COVID-19 pandemic and associated economic struggles and losses.

Spanberger spent more than two hours interacting with and listening to Rappahnnock-Rapidan Community Services leaders who started and are operating the S.E.E. center. Her day in Culpeper started across town at another RRCS facility—the Boxwood Recovery Center, a 28-day residential site for men and women off Brandy Road.

Spanberger, a Democrat who lives in Henrico County, was in Culpeper for the second time last week to promote a bill she is sponsoring that would allocate 10 percent of all federal substance-abuse block grant dollars to recovery services such as those in Culpeper.

Last Saturday, the congresswoman kicked off her re-election campaign during rallies with local Democrats at Mountain Run Winery in Culpeper and party headquarters in Orange.

On Thursday’s tour, Spanberger said funding for recovery services is incredibly important because there are so many areas—such as education and treatment—where they are needed.

“We want to make sure there’s always a locked focus,” she said. “We can make all these investments along the way, but it’s the long-term recovery where the investments make all the others ones, the early investments…(see) the value of it.”

Living-room style

At the S.E.E. center, Spanberger oohed and aw-ed several times about its homey feeling, with dozen or so comfortable rooms for creating art, doing meditation or yoga.

Visitors can take part in group meetings, get counseling, drink coffee with friends in the Encouragement Café, fill out a resume, get online, or complete Virginia Alcohol Safety Action Program classes.

There’s a darkened room where people can turn off the lights, lie down with eyes closed, and listen to a sound machine to decompress. Also offered is an empowerment area, a wellness office, a place to take a hot shower, a connect room for conducting Zoom calls across the services board’s five counties, and family support for those on the journey to wellness and sobriety.

The center’s lighting is gentle and warm, as piano music plays lightly in the background.

Spanberger said the setting alleviates people’s nervousness about walking through the door.

“What I am walking into? Like, every step along the way, it’s a pretty relaxing … I mean I could hang out here all day,” she said. “It’s very welcoming. It’s spalike, right? It’s much fancier than my living room. There’s an intentionality that I think is really interesting.”

Creating that setting was very intentional, Will said.

“We use the living-room model of care, so it is meant to be very relaxing, where someone can come in whether they’re borderline crisis, can find a comfortable environment and, often times, avert the crisis,” he said.

Support, Encourage & Empower

Peer-recovery specialists meet people where they’re at, without judgment, Will said.

“It’s all about helping people explore what works for them,” he said.

“Myself, I did 17 years in the Marine Corps. I was forced to retire due to PTSD and a traumatic brain injury, so I’ve been in recovery with that, Will added. “We also have one of our supervisors who’s in today, he’s in recovery from a long battle with substance-abuse disorder.”

The range of experiences among the peer-recovery specialists helps forge connections on a different level, the veteran said.

“We know what it’s like,” Will said.

The center’s model came from a gentleman in Orange County, Thomas Pratt, a recently retired peer-support specialist and nurse with the Veterans Health Administration, said Jim LaGraffe, director of the 400-employee Community Services Board.

Pratt, once a homeless Navy veteran, created the Veterans X program, the VA’s nationwide peer-recovery program based on the premise that veterans could help themselves as a team.

Pratt recently relocated back to his family farm in the area, LaGraffe said, and has joined the RRCS board. He has brought his experience to the agency, and provided a practical example for achieving recovery over time and to support, encourage and empower.

“He always said that because he was a peer trainer,” Will said. “I said that sounds fantastic. And last year he was like, we have to name this concept if we want to make it come to life. We named it and, a few months later, it came to life.”

Easy access, family support

Will returned to the Community Services, his former employer, in April 2020. Since then, he has helped facilitate local investment in peer-based recovery—from two part-time positions to more than 20 career positions, said Ryan Banks, director of the agency’s behavioral health division. Banks had kept in touch with Will over the years, and lured him back to run the innovative recovery center.

“Anybody coming through the doors generally had to go through rapid access, all these insurance requirements,” she said. “The peer program is outside of that. So at any point in time, they can meet us here for services. And if they need a higher-level care, the peers will support them getting that inside and outside of the agency.”

In the empowerment area, a family support partner interacted via Zoom with a parent from the Fauquier area when Spanberger dropped in. The mom of an adult child with mental health challenges living in coordinated care told the congresswoman how wonderful the outreach from SEE Recovery Center had been.

“Since we have been included and family members in the program and support it’s really made a difference in his recovery and ours because it’s hard to have a child who has mental health challenges, especially now with COVID,” the woman told Spanberger via a big screen. “Any kind

of help you can give towards these grants, whatever keeps these things going, it's unbelievable how hard that is."

An RRCS psychological rehabilitation program formerly occupied the peer-recovery site, but it was not financially viable and participation was low, Banks said.

"It was an existing program that we decided to pivot and change to a different model we thought was going to be more accessible," she said.

As Thursday's tour group moved into the center's main living-room area, Will pointed out Ping Pong tables, darts and a cornhole board they use to host family game nights as well as the Encouragement Café, the venue for the center's most popular group meeting, Coffee & Conversation. His golden-colored service and support dog, from Paws for People, joined him.

The staff members who created the SEE center had the vision and knew that this was going to be something good, Banks said. "And we were right, but we didn't realize how fast it going to do what it did," she said.

Keep them alive

The RRCS crew is focused on reducing stigma, increasing access to services, and keeping people alive.

The new center has already diverted at least one person from a hospital emergency room who was nearing the point of crisis, Banks recounted. The person needed a community connection.

The center doesn't have hard data on how many more people it has kept out of ER, "but we know it to be true," Banks said.

There's no going through hoops to access the S.E.E. Recovery Center—no cost, no paperwork, just a person's name and reason for visiting.

RRCS tried to maintain that integrity and that ease of access, Banks said. The center is for people who don't have a computer or just need a human connection, Will said. It provides preventative care, Spanberger noted.

As another preventative measure, the SEE center and other RRCS facilities in Culpeper, Fauquier, Orange, Madison and Rappahannock for the past month have been distributing free, harm-reduction kits containing Narcan, fentanyl testing strips, first-aid kits, sterilization items, instructions and a list of resources in English and Spanish.

It's all designed to try and keep people alive and well, LaGraffe said.

Development of the kits came about in part due to a Star-Exponent article last year that report 15 overdose deaths in Culpeper in the first half of 2021, the RRCS director said.

“What are we doing? This is one of the things,” LaGraffe said.

In all of 2021, Culpeper had 158 documented overdoses—33 fatal—according to the regional drug task force

“If we can keep them alive long enough to say, ‘Hey, I need help,’ that’s the goal,” Will said. “It was on my five-year plan when I first started. The fact that we got it in a year boggles my mind.”

“Wow, that’s amazing,” Spanberger replied.

The RRCS staff agrees, and seems dedicated to continuing the journey alongside its clients.

Pick up Tuesday’s Star-Exponent to read more about the first stop in the congresswoman’s tour Thursday of Culpeper recovery centers, which was Boxwood, originally located along U.S. 29 in legendary local entrepreneur Ruby Beck’s old restaurant and motel.

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