Bolstering Recovery Capital with Successful Life Skills: A National Implementation Project with Recovery Housing

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SMART Empowerment for All

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Objectives

- Fletcher Group
- Addressing SUD – Health Related Social Needs
- Chronic Care Model – SMART/SLS
- Project Purpose and Objectives
- Program Components
- Program Evaluation
- Results
- Key Considerations
- Q&A

Acknowledgements

- Thank you to our funding agency, the Health Resources and Services Administration (HRSA) for their support with this pilot initiative.
- Special thanks to the SMART Recovery team for collaborating with us on this project and to all the recovery housing programs, their leadership, staff, and residents.

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Fletcher Group

- National 501c3 nonprofit founded in 2017 by former Kentucky Governor, Dr. Ernie Fletcher and his wife, Glenna
- Goal to support those in society move from the disease of addiction and the devastation of homelessness to lives of hope, dignity, and fulfillment through extending the “recovery ecosystem” model across the country.
- Received a national grant from the Health Resources and Services Administration (HRSA) in 2019 to operate a Rural Center of Excellence in Recovery Housing
  - Provision of technical assistance and conduct of research and evaluation to expand and improve recovery housing in rural areas

Fletcher Group

BUILDING RECOVERY ECOSYSTEMS

- Recently received a 5-year HRSA grant to continue expanding and improving recovery supports as a Rural Center of Excellence in Recovery

Substance Use Disorder – National Epidemic

- 111,380 predicted fatal drug overdoses (Sept 2022 – 2023) (CDC, 2024)
- Substance use disorder (SUD) presents multifaceted challenges (Stone et al., 2012; Ogden et al., 2022)
  - Combination of risk factors contributing to development
- Recovery from SUD challenging – average of 5 attempts before resolution (Kelly et al., 2019)
- 80% of health outcomes are impacted by non-clinical social drivers of health (Elevance Health, 2023)

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Health Related Social Needs

- Recovery supports such as safe and supportive **recovery housing**, peer support, education, employment, and life skills are critical to supporting the development of recovery capital.

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Recovery Housing

- **SAMHSA:** Housing or having a home – a stable and safe place to live – is one of the major dimensions that support a life in recovery (SAMHSA, 2018)
- Although unknown, estimates indicate **10,358 to ~18,000** recovery residences in the U.S. (Mericle et al., 2022; Jason et al., 2020)
- NARR Levels I-IV, increasing with staffing/clinical integration (NARR, 2024)
- Heterogenous landscape with services/supports, capacities, funding, etc.
- Offer range of services and supports (Borkman et al., 1998)
  - Peer and recovery support and navigation
  - Case management
  - Didactic and mutual support groups (12 step, SMART, Recovery Dynamics)
  - Building recovery capital through participation in house activities
  - Vocational assessment, training and job coaching
  - Medication supports and coordination

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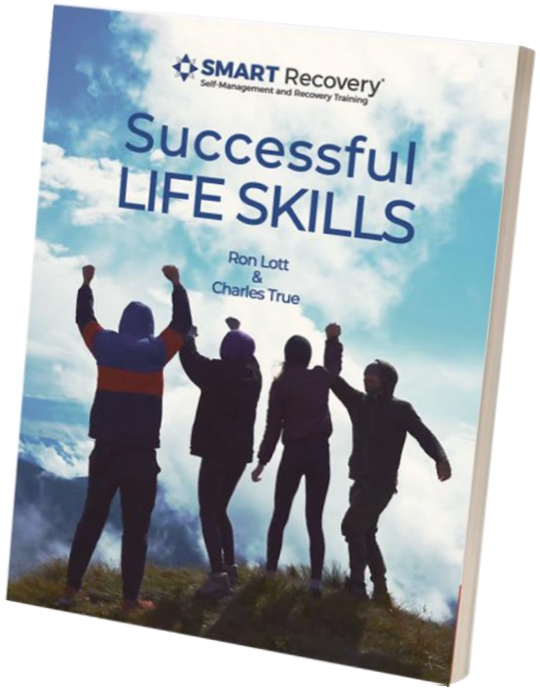
SUD is a Chronic Disease

- **Stanford Chronic Disease Self-Management Program:** based on the premise that all people with chronic diseases share similar preconceptions and have the capacity to take responsibility in managing several aspects of their health (Hudon et al., 2016)
- Self Management and Recovery Training (SMART)'s Successful Life Skills
  - ✓ Evidence-based program
  - ✓ Self-Management = central principle
  - ✓ Cost-effective/sustainable

Potential to be a low-barrier, adjunctive recovery support service for recovery housing programs

SMART Recovery®
Life beyond addiction



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Implementing SMART SLS in Recovery Housing

- **Goal:** Determine the impact of SMART on resident-reported recovery outcomes and implementation factors (barriers and facilitators) reported by recovery housing staff members

- **Participating Recovery Houses:**
  - Receive SMART SLS Facilitator training (up to two staff)
  - Receive books and technology
  - Matched with facilitator, deliver sessions remotely
  - Participate in evaluation

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Methods

- **Evaluation component includes brief surveys:**

  [Participating Residents] - Intake (prior to first class), 6-session, 12-session, 3-month follow-up - Anonymous Qualtrics links shared with house (links and QR codes)
  [Staff] – House characteristics, implementations barriers and facilitators survey post-12 session and brief follow-up interview

- **Outcomes of interest:**

  [**Participating Residents**] - change in recovery capital (BARC-10), anxiety and depression (PHQ-4), perceived alliance (FRHAM-12), and evaluation metrics (i.e., importance of SMART on long-term recovery and confidence in application of skills learned)
  [**Staff**] – implementation barriers and facilitators

✓ Study reviewed and approved by Western Copernicus Institutional Review Board (WCG-IRB)

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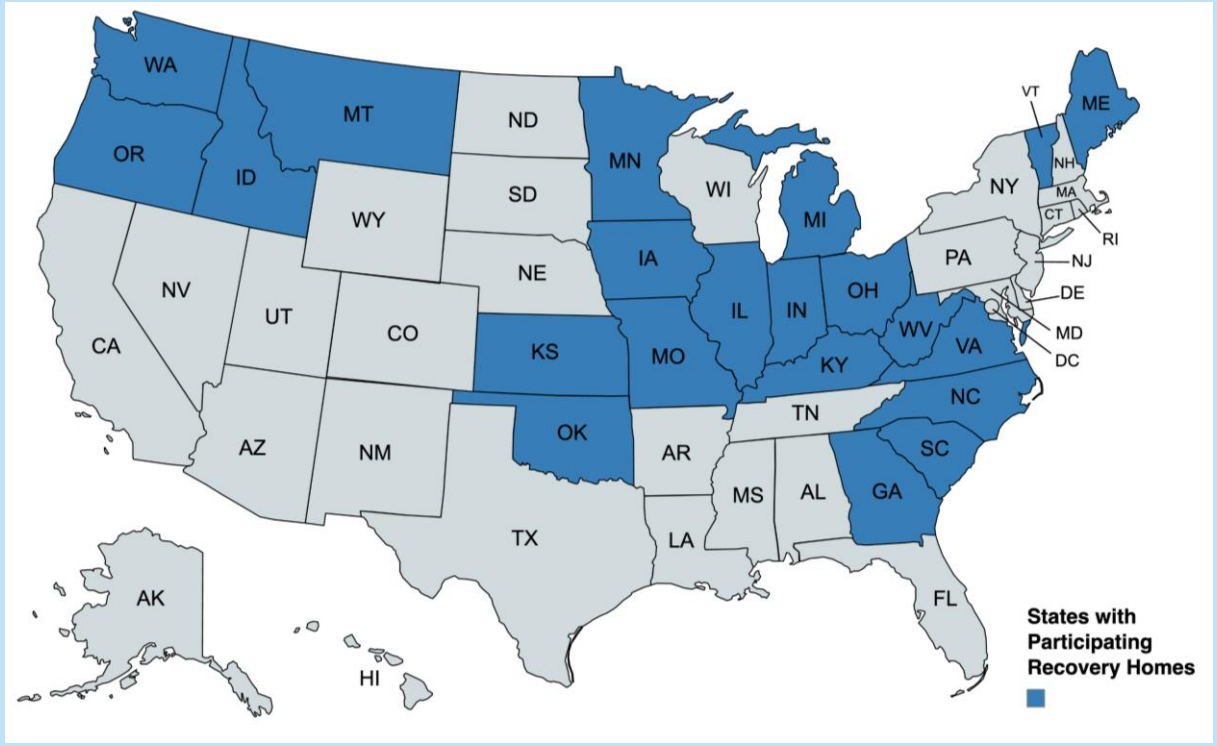
Study Findings

- 49 rural-located recovery homes in 21 states, enrolled



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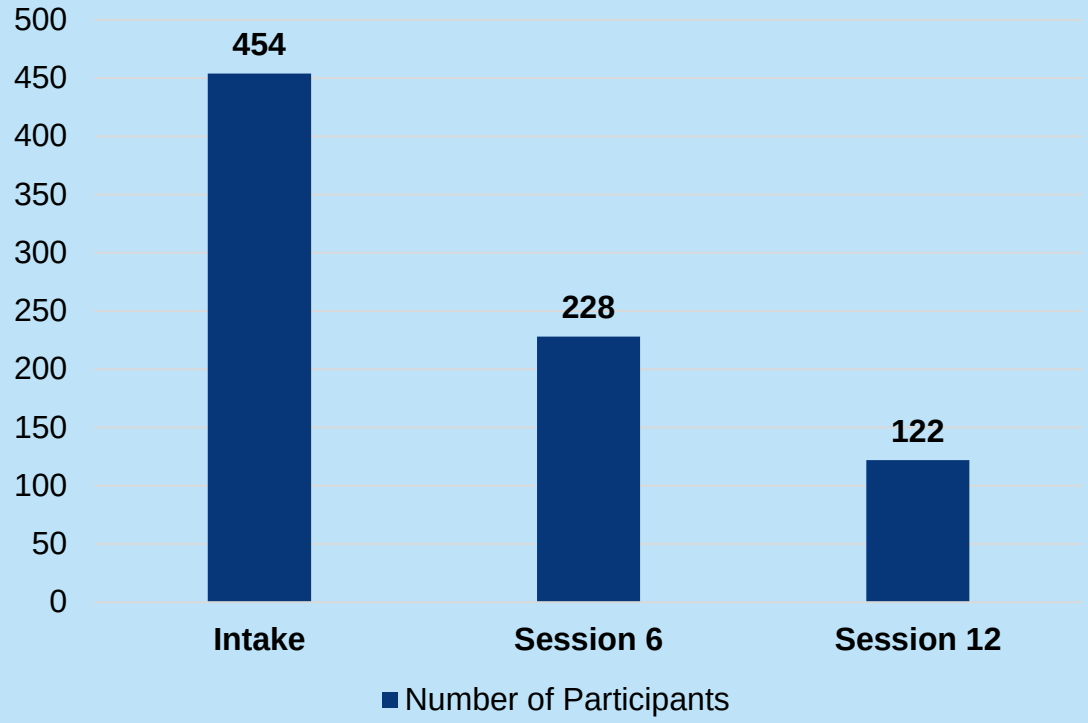
Study Findings

- 454 residents completed intake surveys



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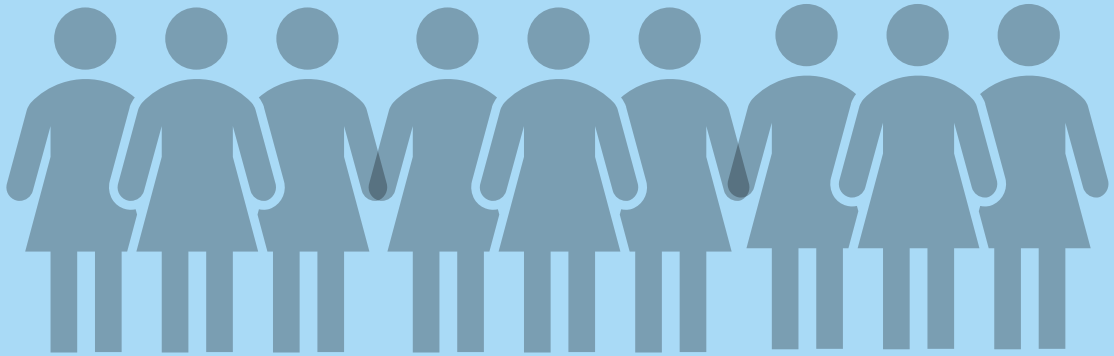
Who Participated?

- Intake Demographics (N=454)
  - Most residents (58%) report being female, Caucasian (83%), employed at intake (54%), with an average age of 39.
  - Participating residents reported an average age at first use of 16, and 40% reported having overdosed.
  - The majority (60%) reported that it was their first time residing in a recovery home.
  - A quarter (24%) indicated it was their first recovery attempt.



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SMART Curriculum

- At Session 6 (N=224)
  - Participants asked to rank “importance”, “confidence” and “difficulty” of aspects of SMART using a 1 – 10 scale:
    - SMART is important to my long-term recovery = **7.4**
    - I am confident in my ability to implement the tools obtained from SMART = **8.0**
    - Difficulty of course materials = **3.4**

- At Session 12 (N=121)
  - Participants asked to rank “importance”, “confidence” and “difficulty” of aspects of SMART using a 1 – 10 scale:
    - SMART is important to my long-term recovery = **7.6**
    - I am confident in my ability to implement the tools obtained from SMART = **8.2**
    - Difficulty of course materials = **3.0**

- **69%** (N=84) at session 12 agree that the course increased their knowledge about recovery, met their approval, was implementable, they have been using skills obtained, and that they would recommend SMART to others.

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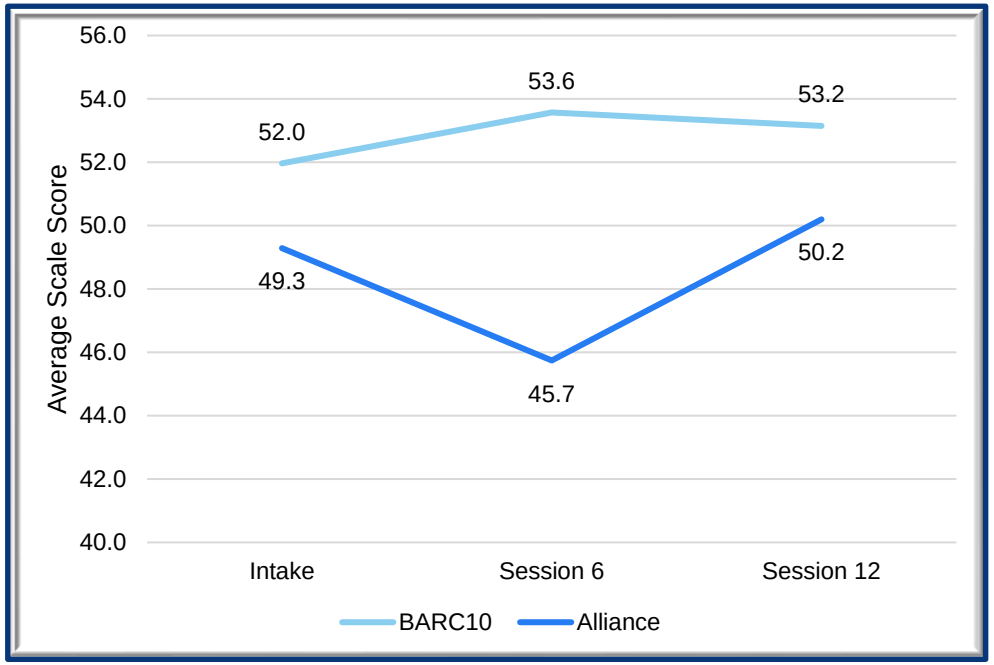
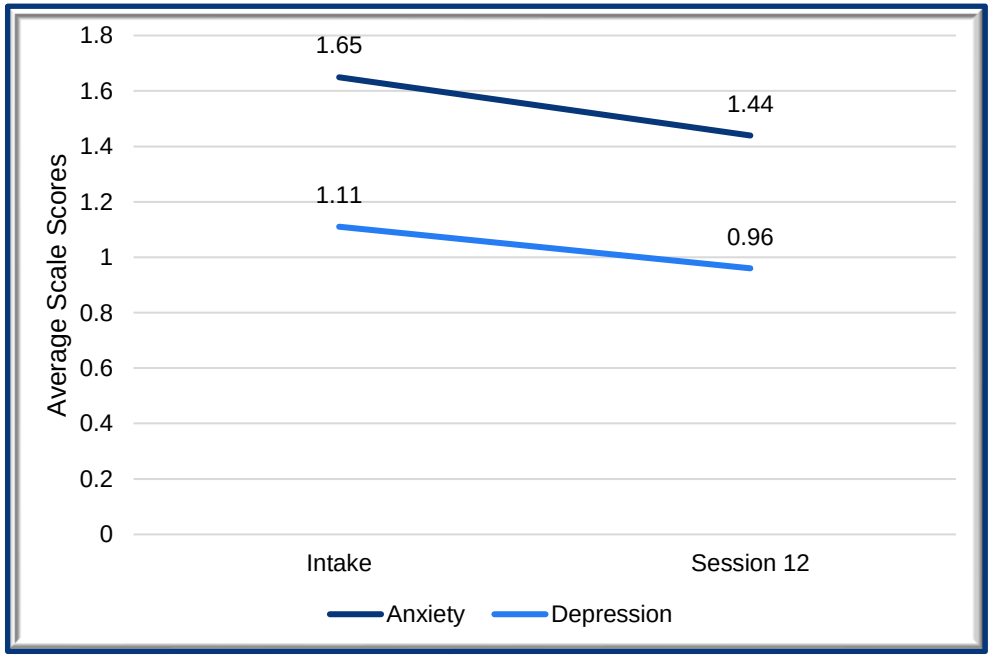
Preliminary Recovery Outcomes

Changes in BARC-10 and Alliance from Intake to 12-session (N=35)



Changes in Anxiety and Depression from Intake to 12-session (N=35)



- **Comparing group means across time using t-tests, no results are statistically significant.**

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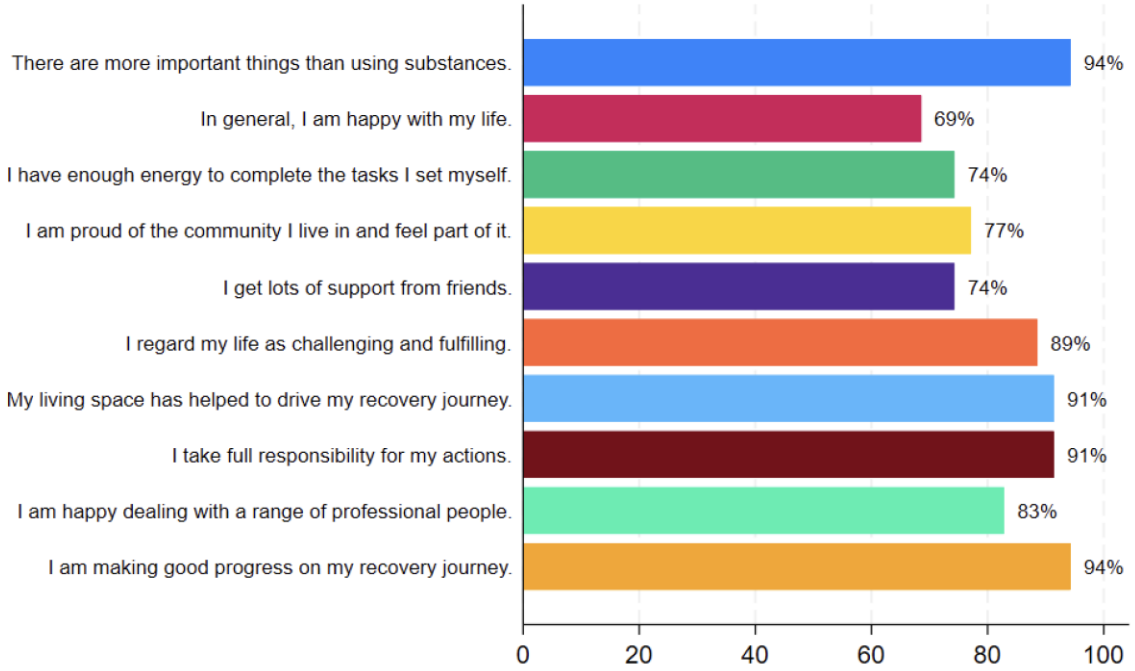
Preliminary Recovery Outcomes

Percent Agreement with BARC-10 Items At Intake (N=35)



Percent Agreement with BARC-10 Items At Session 12 (N=35)

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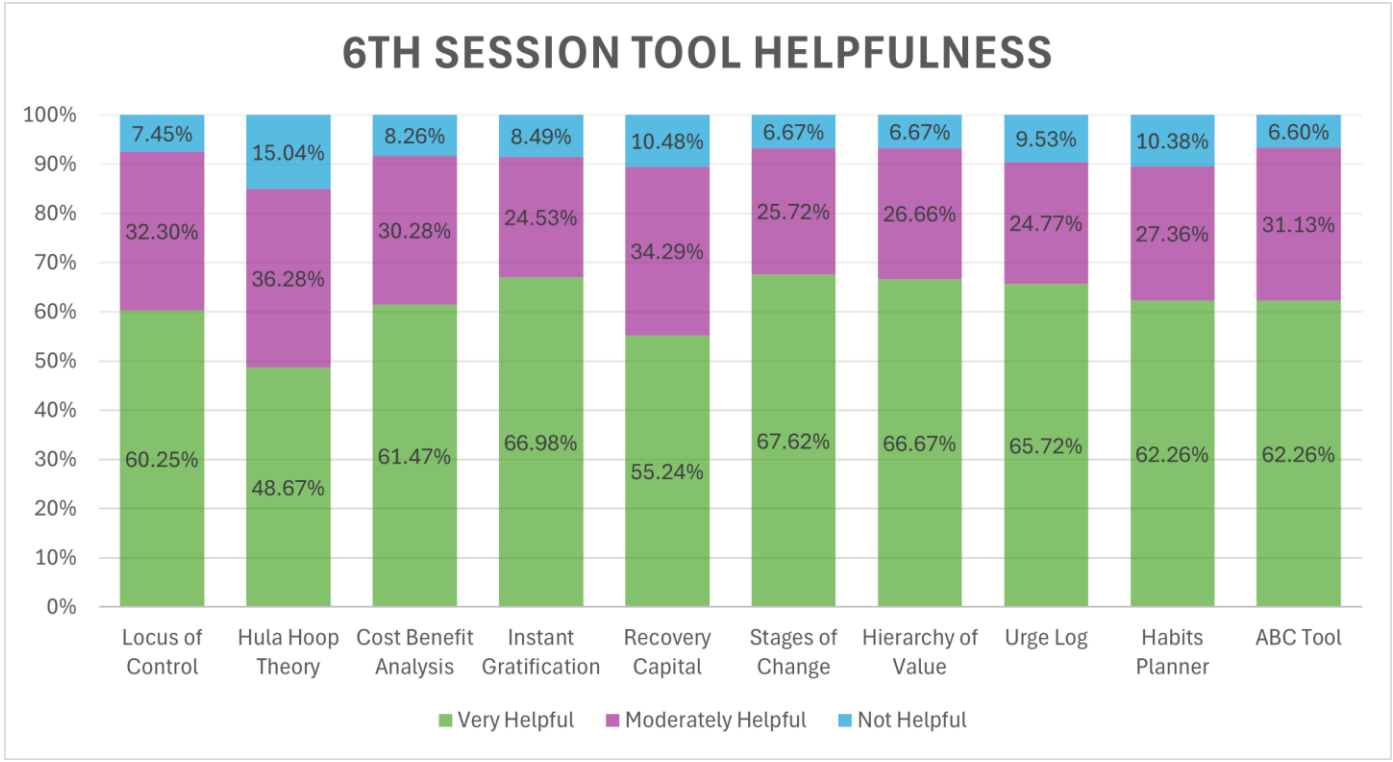
Participant Feedback

6th Session Tool Helpfulness

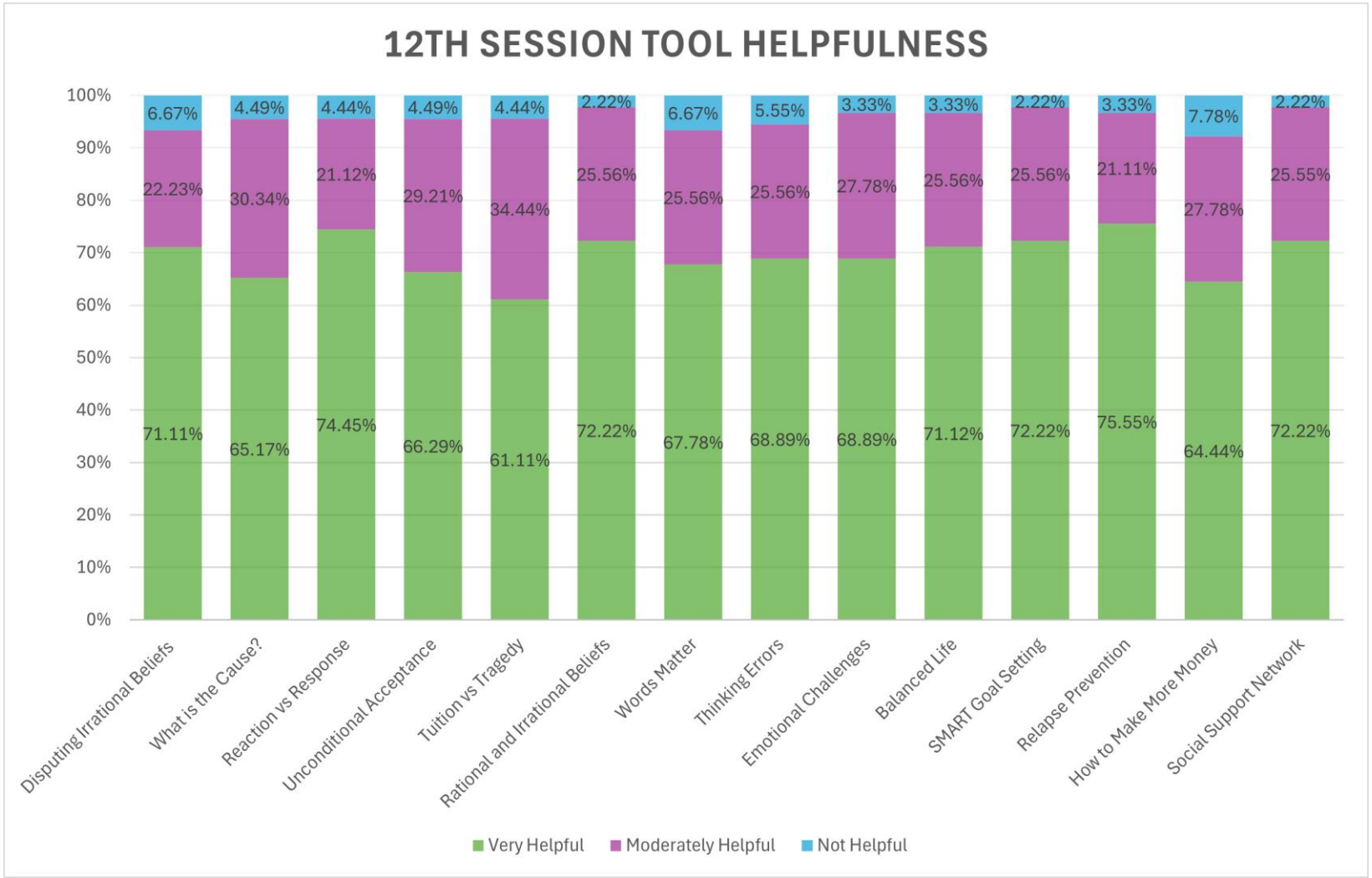
- **Locus of Control:** How much control people feel they have over things that impact their lives.
- **Hula Hoop Theory:** You can only control what goes on in your life and cannot control anything outside of it.
- **Cost Benefit Analysis:** Listing the benefits and drawbacks of doing a certain activity.
- **The Problem of Instant Gratification:** Only paying attention to the immediate benefits of addictive behavior causes urges to grow.
- **Recovery Capital:** Assets that aid individuals in recovery.
- **Stages of Change:** The stage you are in during the recovery process, from pre-contemplation to maintenance.
- **Hierarchy of Values:** What are your most important values and what do you want for the future?
- **Urge Log:** When are you having urges, what triggered them, and how did you cope?
- **Habits Planner:** Planning your time to include meaningful activities and develop a positive routine (habits).
- **ABC Tool:** Activating event (trigger), beliefs about the event, consequence of beliefs, dispute beliefs, effective change in thinking.



N=106

12th Session Tool Helpfulness

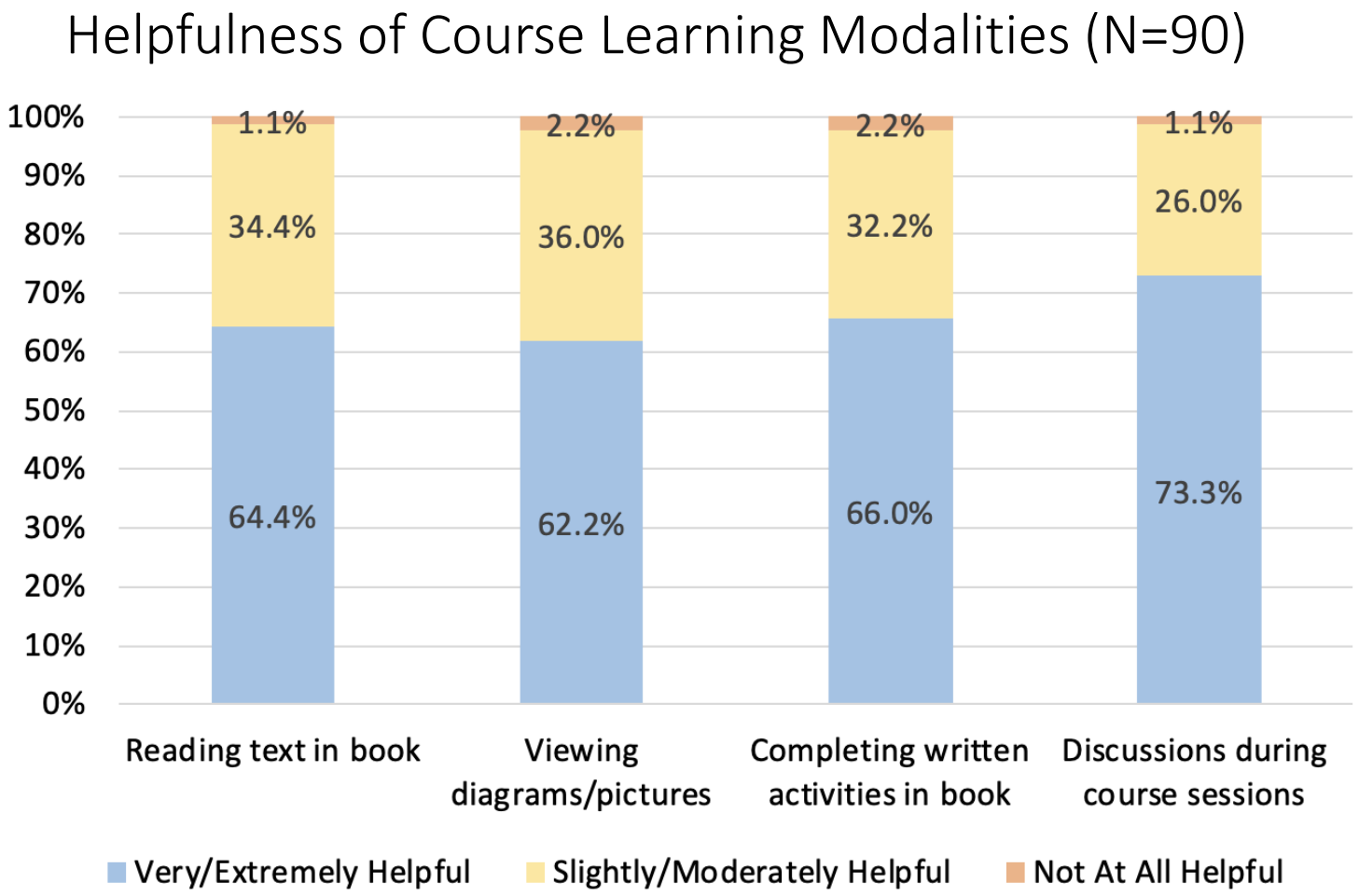
- **Disputing Irrational Beliefs:** Looking at potentially harmful beliefs through a new lens.
- **What is the Cause?**: Determining the cause or meaning of beliefs.
- **Reaction vs Response:** Reacting is acting without thinking vs responding using reason.
- **Unconditional Acceptance:** Accepting that mistakes happen and it is how we learn, accepting yourself and others as they are.
- **Tuition vs Tragedy:** Learning from your mistakes (tuition) vs not learning (tragedy).
- **Rational and Irrational Beliefs:** Learning the difference between rational and irrational beliefs.
- **Words Matter:** Changing the words you use to avoid absolutes/negatives (must, can't unbearable, etc.)
- **Criminal Thinking/Thinking Errors:** Avoiding blame/ rationalizing and other errors in thinking.
- **Emotional Challenges:** Anger, stress, thrill-seeking, and depression- changing thinking to manage.
- **Balanced Life:** How to balance what you spend your time on such as work, play, rest, etc.



N=90

Helpfulness of Course Learning Modalities

- Most found all modalities at least slightly helpful
- Most helpful modality - course discussions (73%)



Staff Perspectives (N=6)

Barriers:

1. Conflicting priorities (e.g., job schedules, other meetings, etc.) for residents is a barrier for session participation.
2. Difficulties with equipment (zoom, microphones, cameras, etc.)
3. Virtual facilitation – less engagement.
4. Scheduling difficulties (varying resident demands)

Facilitators:

1. Enabling residents to participate from locations of their choosing (i.e., from their own rooms or in common areas).
2. Reminders posted on house calendar.
3. Engaging facilitators.
4. Having a staff member on site to support.

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Staff Perspectives – Quotes

Program is Useful Despite Resident Scheduling Conflicts

"There is not, I don't believe that there's going to be one time every week that for 12 weeks, every single person in the program is going to be able to make for whatever reason, you know, I think encouraging them to, you know, continue to look at the class material and like our, our ladies were even going to, we started another, um, SMART discussion meeting in town."

Importance of in-person Co-Facilitator when Use of Online Facilitation

"And what I do to, or what I found makes it most effective is to have a point person in person. Right, so kind of co-facilitating with someone who is there, even if it is one of the residents".

"Sometimes it was kind of hard to hear and he didn't always hear when people were talking."

The Facilitator is a Critical Program Element

"She used a lot of open-ended questions. She made her stories very relatable to them. Friendly, inviting."

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Sustainability and Alliance

- **81%** indicated that they plan to continue providing SMART Recovery
- **63%** agreed that residents have used the SMART skills to enhance their interactions with one another.
- **75%** agreed that participation in SMART has improved peer mentor/counselor - resident interactions.
- **56%** agreed that there is a greater degree of trust in meetings between residents that participated in SMART and peer mentors/counselors.
- **75%** agreed that there is a greater degree of shared agreement on recovery goals between residents that participated in SMART and peer mentors/counselors.

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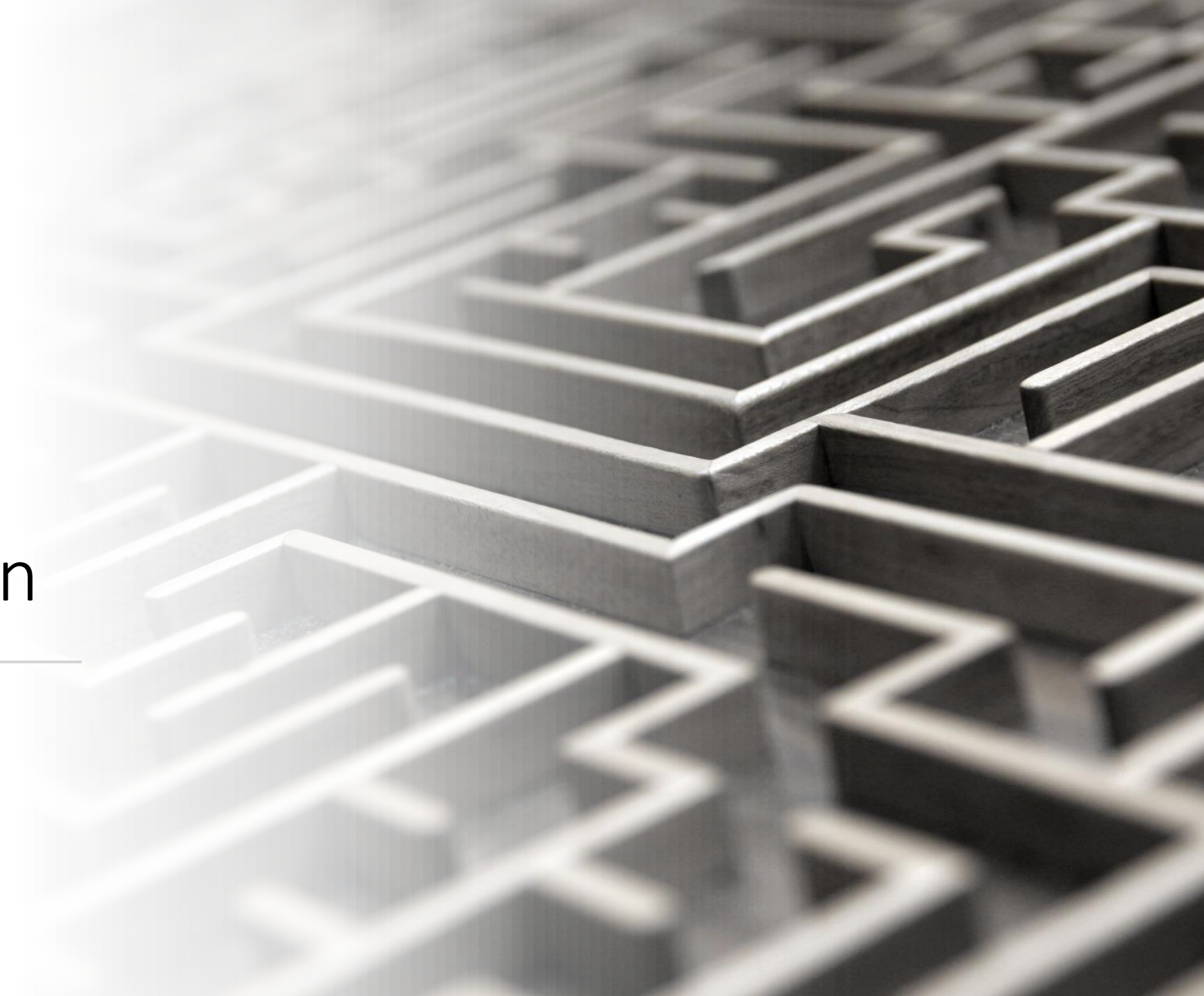
Barriers & Facilitators to Implementation



Implementation Facilitators

“What actions helped your recovery house with implementation?”

(N=6)

SMART curriculum/workbook
SMART Facilitator Training
Resident incentive: either monetary or other reward
Mandatory schedule: having session held during a time where everyone could attend
In-person staff: staff assisting during the session (assisting/supporting SMART facilitator)
Group cohesion
Facilitators: if a facilitator is particularly good at engaging a group
Residents: engaged with the group
Onboarding

Implementation Barriers

"Did you encounter barriers while implementing the program?"

(N=6)

Schedule conflicts
Survey component: issues surrounding surveys
Need help to prepare for sustainability of offering curriculum after 12-week period ends
Facilitator (facilitator not able to engage with residents, or other barrier)
Technology (to run the meeting w/ virtual facilitator)
Philosophical compatibility: with 12-step / faith-based
Onboarding
Resident reluctance: (to participate)
Length of curriculum (either too long or short)

Key Takeaways

- Evidence is supportive of SMART SLS's effectiveness as a low-barrier, adjunctive recovery support service for recovery housing programs
- Supports increased alliance of residents/staff
- Reported as sustainable by majority of recovery housing operators
- Flexible sessions to adapt for varying program schedules
- Supports professional development (i.e., facilitator training opportunities for residents)
- Supplement to current mutual aid group offerings (i.e., 12-step)
- Supports self-management of SUD – chronic disease management approach
- Need for continued implementation studies on this program by recovery context (i.e., recovery cafes, recovery community organizations, other), with specific populations, and by geographic location (rural vs. non-rural)

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Importance of Implementation Science

CHAMPION

READINESS

ORGANIZATIONAL FIT

BENEFITS

MODIFIABLE

TECHNICAL SUPPORT

Next Steps

- Further analysis of engagement and associated outcomes by demographic characteristics, substance use disorder types/severity
- Continue examining implementation with Elevance Health Foundation project
  - Non-rural
  - Recovery programs = recovery housing, recovery community organizations, recovery cafes
- Conduct follow-up for assessment of sustainability of SMART SLS with prior participating recovery homes
- Continue collaboration with SMART Team to continue examining best practices for implementation of SMART to reach all people in need of recovery supports

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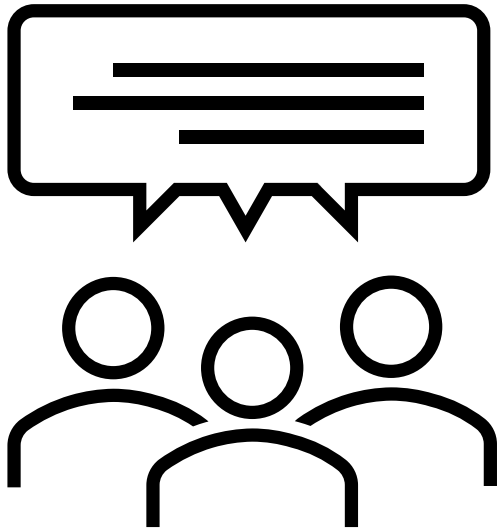
Questions?



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Thank You!

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Questions?

If interested in learning more about implementing SMART Recovery within recovery settings?

Contact use visiting our website www.fletchergroup.org or emailing Michelle Day at mday@fletchergroup.org

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Importance of Implementation Research

- Services may need to be adapted to fit within the organization and best serve individuals in need
- Adaptations based on context can be made
- Assessing facilitators and barriers to implementation supports widespread implementation by context

Factors initially identified by Scheirer, 2005 and used in Tomioka & Braun, 2015

Sustainability factors	Sample questions
1. Readiness	Describe your "readiness" to replicate CDSMP. For example, how adequate was training in the program, data collection, and program monitoring forms? How prepared was your agency?
2. Champions[a]	Describe your experience with program champions for CDSMP? Who and how many people from your organization were helping with CDSMP, and in what ways? What did these champions do? Comment on their effectiveness.
3. Technical assistance[a]	How does your organization have access to technical assistance to sustain the program? Comment on the availability and usefulness of technical assistance as you replicated CDSMP.
4. Program-organization fit[a]	How does CDSMP match your organization's culture or mission? Comment on the level of "fit" between CDSMP and your agency.
5. Program modifiability[a]	Describe your ability to change or modify CDSMP that fit your clients and your agency. Describe your experience making program modifications while trying to maintain fidelity to the original CDSMP design.
6. Perceived program benefits[a]	How did organizational leaders and worker feel CDSMP impacted your clients? How do you think CDSMP benefited the people you served? In what ways has your involvement in CDSMP benefited clients, staff, and your organization?
7. Other (open-ended)	How do you think CDSMP will be sustained by your agency? What are the major factors that contributed to long-term sustainability?