An Evaluation of AmeriCorps-Supported Recovery Coach Programs

Cohort 1 – Fiscal Year 2020

BUNDLED EVALUATION AND CAPACITY BUILDING PROJECT

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Prepared by ICF for the AmeriCorps
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Executive Summary

The United States is facing an unprecedented addiction and overdose epidemic. Drug overdoses have claimed over one million lives since 1999—with over 100,000 lives lost in the last year alone—and increasing annual substance use-related deaths continue to devastate American families (Centers for Disease Control and Prevention [CDC], 2023a). Over-prescription of opioid medications for pain management during the late 1990s has largely contributed to widespread misuse of prescribed and illicit opioids today, with approximately 75 percent of overdoses in the United States involving an opioid in 2021 (CDC, 2023a). Increasing trends in polysubstance drug use (i.e., exposure to more than one drug) pose additional challenges in addressing substance use issues; for instance, almost 80 percent of synthetic opioid-related deaths in 2016 involved alcohol or other drugs such as psychostimulants or antidepressants (CDC, 2023b). The coronavirus disease 2019 (COVID-19) global pandemic and the proliferation of synthetic opioids (e.g., fentanyl) and animal tranquilizers (e.g., xylazine) in many types of drugs have also accelerated drug overdose death rates (CDC, 2023c, 2023d, 2023e).

In 2017, the U.S. Department of Health and Human Services declared a public health emergency in response to the increasing number of opioid-related overdoses and deaths. President Biden has declared the administration's commitment to addressing addiction and the overdose epidemic (The White House, 2022), and the efforts of federal agencies such as AmeriCorps are critical to successfully undertake this national priority.

Due to differences in funding, policies, regulations, available resources, and the overall approach to addressing substance use disorders (SUDs), substance use treatment and harm-reduction options[1] may vary across states. In general, there are medication-assisted and non-medication-assisted treatment approaches for individuals with SUDs. Treatment with medication assistance typically involves regular visits to treatment centers to receive doses of methadone, buprenorphine, or naltrexone. Contrary to popular belief, these medications do not simulate the chemical effects of opioids, but rather lessen urges and withdrawal symptoms to ease the recovery process (American Society of Addiction Medicine, 2016). The majority of medication assistance programs require participants to simultaneously attend counseling services.

One promising strategy to address the rising rates of SUDs and drug overdose is recovery coaching, which is a type of peer support. Recovery coaching is the process in which a nonclinical professional (i.e., coaches) with lived experience with an SUD provides guidance to individuals with an SUD by helping them to access care and supporting them in the removal of barriers to recovery (Zandniapour et al., 2020). Recovery coaches assist individuals seeking treatment by guiding the development of a personalized recovery plan, tailored to the strengths, needs, and goals of each individual to promote long-term recovery. Recovery coaching is a strategy that may be used alongside other treatment options, such as medication-assisted treatment. Recovery coaching is defined in this report as including recovery coaching by state certified coaches as well

[1] The Substance Abuse and Mental Health Services Administration (SAMHSA) defines harm reduction as "an approach that emphasizes engaging directly with people who use drugs to prevent overdose and infectious disease transmission, improve the physical, mental, and social well-being of those served, and offer low-threshold options for accessing substance use disorder treatment and other health care services." For more information, please see the SAMHSA web page on harm reduction.

A Note on Terminology

A recovery coach is a nonclinical professional who typically helps patients access care and supports, removing barriers to recovery and/or increasing recovery capital, augments professional medical/clinical treatment, and aids in service navigation. This position often requires state certification. This report uses the term recovery coach to describe national service members and paid staff who may have lived experience with a substance use disorder (SUD) and are providing recovery coaching and navigation support. This definition encompasses the broad range of terms used to describe recovery coaching by each organization in this report. Recovery coaches within AmeriCorps-supported organizations do not necessarily have state certification though a subset of them may pursue such certification.

as other forms of coaching and support provided by non-certified coaches, navigators, mentors, and support staff following a peer support services model for SUD recovery.

Between fiscal year (FY) 2017 and FY 2022, AmeriCorps invested over $129 million to fund projects addressing opioid addiction and other SUDs. AmeriCorps' mission to combat the complex issues around substance use prevention includes research and evaluation of promising treatment options. In 2020, AmeriCorps contracted with an independent research firm, ICF, to provide a comprehensive evaluation of projects that use recovery coaching models to understand the best practices for effective recovery coaching programs. The initial focus was on recovery from opioid use disorders but this focus was later expanded to evaluate recovery from SUDs more broadly. This evaluation included bundling projects with similar programs and outcomes across AmeriCorps funding streams as well as providing participating organizations with evaluation capacity building sessions. AmeriCorps seeks to improve support for locally-driven and innovative solutions for communities seeking to address SUDs through this evaluation of the entire program life cycle and the incorporation of capacity building and dissemination activities.

Methodology

A mixed methods approach was used to examine the implementation of recovery coaching models across different organizations as well as outcomes for organizations, recovery coaches, and program participants. This study focused on three overarching research objectives: 1) to determine what recovery coaching models look like; 2) to describe promising practices and challenges in implementing recovery coaching models; and 3) to measure the effectiveness of the recovery coaching model in improving outcomes for the organizations, recovery coaches, and program participants (also referred to as "clients"). These overarching objectives are broken down into implementation and outcome research questions (exhibit ES-1).

EXHIBIT ES-1.—Research questions guiding the evaluation

Implementation Questions	Outcome Questions
• How do organizations recruit and work with recovery coaches to provide the service?	• To what extent do participating organizations demonstrate an increased organizational capacity to provide service?

Implementation Questions	Outcome Questions
• How do organizations work with partners to help program participants fill in the gaps of their holistic treatment plans? • What kinds of support do organizations provide in program monitoring and tracking (e.g., outreach, enrollment, referrals/connections to services, etc.)? • To what extent are organizations able to leverage additional resources to support their programs? • What types of activities do recovery coaches engage in and what is the setting, modality, frequency, intensity, and duration of the services they provide? • What are recovery coaches' experiences in interacting with participating organizations and program participants? What are the successes and challenges?	• To what extent do participating organizations demonstrate an increased ability to leverage grant (i.e., financial) support? • To what extent do participating organizations increase their collaboration with partners and community resources? • To what extent do recovery coaches improve knowledge, attitudes, and behaviors? • To what extent do program participants improve their recovery capital as a result of participation in recovery coaching? • To what extent do program participants increase attendance to physical and behavioral health services because of participation in recovery coaching? • To what extent do program participants experience a decrease in substance use because of participation in recovery coaching?

Study Sites

Seventeen AmeriCorps project applications from fiscal year FY 2020, including AmeriCorps State and National grantees and AmeriCorps VISTA sponsors, were reviewed to determine whether the programs used a recovery coaching model. Under AmeriCorps State and National, organizations leverage the use of AmeriCorps members to help them address a community need. Under AmeriCorps VISTA, organizations sponsor individuals ("VISTAs") to create or expand programs designed to empower individuals and communities to overcome poverty.

Eight organizations initially agreed to participate; however, four organizations ultimately withdrew from the study in the months that followed. Two of the organizations that eventually withdrew from the study participated in some early evaluation activities, including the initial wave of surveys and early sessions from the evaluation capacity building component. Loss of organizations' participation posed a challenge for studying this population; while some organizations cited concern about maintaining the privacy of their program participants others dropped out without a stated reason. The COVID-19 pandemic further hindered the ability of some organizations and individuals to fully participate in the evaluation process as they pivoted to adapt their programs to meet changing public health guidance. Ultimately, the study included the four organizations that use a recovery coaching model (exhibit ES-2).

EXHIBIT ES-2.—Overview of participating organizations

Organization	Project Mission and Target Population	Role of AmeriCorps Members/VISTAs
Above and Beyond Family Recovery Center (AnB) – Chicago, Ill. & neighboring suburbs (with a focus on Chicago's West Side)	**Mission:** Addiction recovery services and supportive services, such as housing and employment assistance, to all individuals, including those who are unable to pay **Focus population:** Low-income individuals and communities including individuals and families experiencing homelessness, unemployed individuals, individuals with disabilities, formerly incarcerated adults, veterans, and military families (many participants are chronically homeless as defined by the U.S. Department of Housing and Urban Development, 2015)	**7 VISTAs:** Provide project management and capacity building services related to housing and employment, community outreach, and education (coaching services were provided by paid staff, i.e., "certified recovery support specialists")
Foundation for Recovery (FFR) – Nevada	**Mission:** Peer recovery support services for mental health and substance use disorder (SUD) recovery to vulnerable teenaged and adult populations **Focus population:** Individuals in detention centers, jails, and emergency room departments, and in underserved areas with nonexistent or extremely limited services (such as rural and frontier communities)	**10+ AmeriCorps members:** Serve as "recovery navigators," delivering peer recovery support services (alongside paid employees who work as "peer recovery support specialists")
Healing Action Network (Healing Action) – St. Louis, Mo. & surrounding areas	**Mission:** Preventative mental health services through case management, opioid education, therapeutic counseling, peer support, and community education **Focus population:** Adult survivors of commercial sexual exploitation, which includes sex trafficking, prostitution, survival sex, escorting, stripping, and pornography; most clients have experienced complex, multilayered trauma and have mental health-related diagnoses	**11 AmeriCorps members:** Provide case management, opioid education, and naloxone distribution, therapeutic counseling, and community education (they do not provide coaching services; those are delivered by "peer support specialists" with lived experience in SUDs and trafficking)
Recovery Corps – Minnesota & Illinois	**Mission:** Peer support to assist those in recovery with achieving their goals and increasing recovery capital **Focus population:** Teens and adults in recovery for various types of SUDs being served across multiple organization types, including recovery residence associations, recovery community organizations, treatment facilities, collegiate recovery organizations, and recovery high schools	**58 AmeriCorps members:** Serve as either recovery navigators, delivering peer support and recovery coaching services, or opioid response project coordinators; members additionally help engage volunteers in service projects

Data Sources and Data Collection

This study used a mix of quantitative and qualitative data sources:

1. **Organization program documents,** which included project applications, program documents, employee handbooks, marketing materials, and data analyses.
2. **Surveys of key organization informant groups,** which included online surveys for project directors, recovery coaches, program participants, and comparison group members, to assess program models, strategies, and outcomes.
   - ***Project director/manager surveys*** assessed organizational capacity, staff recruitment, ability to leverage grant financial support, and collaboration with partners and community resources. One partner who provided recovery services also completed this survey.
   - ***Recovery coach surveys*** assessed knowledge, attitudes, and behaviors; activities and services provided; experiences with the organizations; and experiences with program participants. The survey included items for AmeriCorps members.
   - ***Program participant and comparison group surveys*** assessed recovery capital, attendance to physical and behavioral health services, incidence of substance use, and experiences interacting with the organizations and recovery coaches.

Two waves of survey data collection were completed: a baseline survey from November 2021 to March 2022 and a follow-up survey from November 2022 to January 2023. Data were collected from program participants through anonymous paper-based or digital surveys. Only comparison group respondents were given a $25 Amazon gift card as an incentive for their participation in the survey.

Virtual site visits were conducted from May through June 2022 with all four participating organizations and included:

- 90-minute in-depth interviews with project directors
- 60-minute in-depth interviews with recovery coaches
- 30-minute structured interviews with partner organizations and AmeriCorps members
- 60-minute focus groups with program participants

Due to the difficulty of recruiting program participants for focus groups, 30-minute interviews with individual program participants were conducted. Program participants were given $25 Amazon gift cards to incentivize participation in focus groups.

Evaluation Context: COVID-19

Grantees shifted programming to reflect public health guidance, causing some grantees to struggle to adapt their programs. As a result, some grantees left the study. Remaining grantees noted the negative effect the pandemic had on participants in their respective programs.

Exhibit ES-3 presents the number of surveys completed and the number of participants for interviews or focus groups.

EXHIBIT ES-3.—Number of surveys completed and interview/focus group participants by respondent group

Respondent Group	Surveys	Interviews/Focus Groups
Project Directors	5	5
Recovery Coaches	41	5
AmeriCorps Members	1	4
Program Partner	1	3
Program Participants	22	12
Comparison Group	18	-

Survey Sample

Over half of the surveyed recovery coaches (60 percent) were women and White (60 percent), and most were non-Hispanic (89 percent). The majority of recovery coaches (81 percent) were between the ages of 30 and 59. Twenty-two percent of recovery coaches were college graduates and 46 percent had some college/technical school experience.

Almost one-third of the program participant survey sample—which stemmed from all four participating organization sites—were women (32 percent), over two-thirds were White (68 percent), and most identified as non-Hispanic (86 percent). Over half of the program participants (59 percent) were between the ages of 30 and 49 and the majority had a high school diploma or above (82 percent). The comparison group sample—which stemmed from just two participating organization sites—was predominantly White (44 percent) and male (39 percent), and largely identified as non-Hispanic (67 percent). Most comparison group participants were between the ages of 30 and 49 (44 percent) and had a high school diploma or above (56 percent).

Response rates could only be calculated for surveys that were sent directly by the evaluation team to the participants. The response rate for recovery coaches was 67.5 percent in the first wave and 32.6 percent in the second wave. Ten recovery coaches had surveys in both waves of data collection. For program participants, the response rate was 20.8 percent in the first wave and 7.8 percent in the second wave. The response rate for comparison group members was 28.1 percent in the first wave and 17.2 percent in the second wave.

Analysis

Survey responses were analyzed using IBM SPSS Statistics software and R software. Quantitative analyses used pooled data from the four participating organizations and included descriptive statistics (e.g., percentages, means). If a respondent completed both the baseline and follow-up survey, the follow-up response was included in the reporting of aggregate numbers. Subgroup differences were not examined due to small sample sizes. Outcomes between program participants and comparison group members were compared using nonparametric tests.

Interviews and focus groups were audio-recorded and transcribed for analysis. All qualitative data were indexed and coded for descriptive and thematic analyses using NVivo data analysis software. Interpretive analyses that tested the research questions and examined the relationships were conducted between the elements of the program models. The themes that emerged most consistently—as well as themes that were less consistent but noteworthy—were identified.

Implementation Findings

Recovery Coaching Models, Services, and Activities

All participating organization use peer recovery models and incorporate the same core components of lived experience, culturally responsive services, harm-reduction strategies, and holistic care meet the needs of their participants.

All participating organizations used **peer recovery models** and required recovery coaches to have lived experience of being in recovery. The implementation of peer-based models emphasized the importance of **lived experience** because it affects relationship building between recovery coaches and program participants. Site visit participants discussed the loneliness of addiction and emphasized the importance of empathy and having experienced similar challenges as the program participant to support them in their journey through recovery.

All participating organizations strive to provide **culturally appropriate services** by hiring individuals representing the communities they serve and providing continuing education to develop culturally appropriate interactions with peers. However, only 60 percent of project directors reported that racial, ethnic, and cultural identities were incorporated into treatment plans. Despite this, 87 percent of recovery coaches and 74 percent of program participants found that the services reflected participants' culture or worldview completely or very well.

All participating organizations also use some form of **harm-reduction strategies**—either themselves or through a partner—such as providing Narcan, fentanyl test kits, or needle exchanges to program participants, to meet participants where they are rather than shaming them for use.

Holistic care is another common program component for all participating organizations. The participating organizations see their program's purpose as more than just supporting recovery from SUDs, and incorporate a care model that considers the whole person in recovery. Holistic care encompasses in-house services and referrals for personalized services, such as education, emergency shelters, employment, food, housing, legal services, and physical or behavioral health providers. Programs also provide a range of services that are not directly recovery-related, which may include supports for transportation, basic provisions (e.g., food, clothing), life skills, art therapy, and other classes (e.g., dance, yoga).

All participating organizations work with other organizations and providers in their area to facilitate client referrals for additional services.

The types of services for referral varied but were mainly in the areas of medical services (e.g., detoxes, checkups, screenings, therapy) and supportive services (e.g., housing, financial support, meals, clothing, employment). Two participating organizations have over 100 linkage agreements for various services, and resource lists are available for program participants and recovery coaches. Participating organizations developed partnerships through broader statewide coalitions, coordinating with local universities and employers, conducting online research, and posting on social media. In addition, one organization's AmeriCorps VISTA position description includes conducting community outreach and linking resources.

During the COVID-19 pandemic, participating organizations faced challenges providing in-person services and resources.

Only Above and Beyond Family Recovery Center (AnB) remained open throughout 2020 and 2021, while the other three participating organizations temporarily discontinued in-person services. Participating organizations implemented measures to protect against COVID-19, including masking, temperature checks,

social distancing, and outdoor services. They provided resources such as food drop-offs, laundry money, and basic provision deliveries. Virtual services were made possible through special grants to provide program participants with computers, tablets, phones, or Wi-Fi hotspots. Technical support fell on organization staff, and some did not have the capacity to always assist. Overall, the organizations found value in virtual services, increasing their capacity for them since the beginning of the pandemic, and plan to continue to offer the option of virtual or hybrid services.

Multiple organizations have moved overhead processes—such as training and onboarding—online, and they plan to continue to provide these virtually.

While recognizing the benefits and importance of virtual services, some participating organizations also question their efficacy, especially within the first few months of recovery. Interviewees agreed that the vulnerable populations the organizations serve were negatively affected by diminished in-person services and resources, particularly at the height of the pandemic. In-person services were highly preferable to almost all interviewees because recovery coaching draws its success from human connections and relationships.

Recovery Coach Identification, Recruitment, and Training

Participating organizations use multiple methods to identify and recruit potential recovery coaches.

Participating organizations recruit recovery coaches through various methods, including their own programs, community recovery programs, schools, universities, job websites, online recovery networks, and personal connections. Interviewees identified several important skills for recovery coaches to have. In addition to lived experience in recovery, a well-qualified recovery coach is compassionate, patient, and has the ability to set boundaries. They also possess strong interpersonal and technical skills such as listening, communication, and working with computers.

Participating organizations identified two challenges to recovery coach recruitment and hiring: the criminal history background check and the amount of the member stipend.

The criminal history background check was identified as a barrier to hiring recovery coaches. Three project directors noted that failing the background check can be a problem when hiring recovery coaches, as they expect a certain level of justice involvement. AmeriCorps is open to members with some level of justice involvement if they are honest about it. However, members with justice involvement are sometimes denied based on the background check, which can be a problem when the organization wishes to select a qualified candidate with a history of justice involvement. Additionally, the AmeriCorps service members' stipend was identified as a barrier to recruitment and hiring, as interviewees noted that the amount is not sufficient.

Certification requirements for recovery coaches varied by state.

The certification process includes a requisite number of hours of education/training, work experience, supervised work, and a certification exam. All participating organization states (Illinois, Minnesota, Missouri, and Nevada) required a passing score on the certification exam. The number of hours of education/training ranged from 35 to 100 hours and the number of hours of supervised practical experience ranged from 25 to 100 hours. The hours of work experience ranged from 475 hours of volunteer or paid work experience to 2,000 hours of supervised work experience. Hiring requirements varied among the participating organizations, with some hiring individuals in training for state certifications while others require certification through the state before hiring. The required amount of sustained recovery time varied by organization, with some requiring 1 year and others 2 years.

Participating organizations require organization-specific training in addition to state certification training.

Participating organizations also require organization-specific training for recovery coaches and other staff. Most director survey respondents reported an onboarding process for recovery coaches. The majority of recovery coaches (90 percent) reported receiving 17 or more hours of training, primarily conducted by someone outside of the organization, with 66 percent using a specific curriculum or manual. All surveyed recovery coaches found the training helpful.

Support

The recovery coaches play a crucial role in supporting program participants in recovery from SUDs and mental health diagnoses.

All recovery coaches interviewed—from all four participating organization sites—provide emotional, informational, affiliational, instrumental, and mental health support to help participants navigate their recovery journey**.** ***Emotional support*** involves listening to program participants, showing concern, and providing empathy. Recovery coaches often use their personal experiences to develop trust and provide emotional support. They help participants feel heard and they understand that every addiction is different, helping participants find their own path to recovery.

Informational support is essential to connect participants to community resources and share knowledge and information. ***Instrumental support*** is another key aspect of recovery support, providing concrete support to accomplish a task. Recovery coaches provide referrals to outside services, such as employment services, food services, emergency shelters, and physical or behavioral health providers. They also provide tangible services, such as assisting participants with housing, food pantries, counseling services, legal services, and employment.

Recovery coaches provide connections to recovery community supports, activities, and services (known as ***affiliational support***), such as Narcotics Anonymous (NA) or Alcoholics Anonymous (AA). They also provide ***mental health support***, assisting individuals with mental health diagnoses, such as post-traumatic stress disorder (PTSD),

Examples of Support Provided by Recovery Coaches

Emotional Support

I said I just want to talk for a minute. And so, they let me talk. They cried with me and they let me get this mess out.
— Program participant

Informational Support

I will definitely give them names of facilities that I have experience with or I've heard good things about and then they [the participants] make the phone call. — Recovery coach

Instrumental Support

[Recovery coaches] are working in conjunction with the counselors to say, "We're looking at housing for afterwards or a job for after or getting a license back." – Project director

Affiliational Support

One important thing is that they provide leisure time—a quiet place to just be—and entertainment like group parties.
– Program participant

Mental Health Support

Every recovery story is different. Some [clients] want therapy, some prefer support. [Recovery coach] puts labels on bricks and creates a "foundation" for recovery. – Recovery coach

depression, or anxiety. Some recovery coaches collaborate with AmeriCorps members to address the mental health needs of program participants who are victims of trauma. Other participating organizations have groups specifically designed to help participants overcome trauma.

Challenges and Solutions

Working with individuals with an SUD can be emotionally challenging.

Recovery coaches face challenges in their role due to overdose incidents, which they may witness, and an otherwise lack of readiness among participants. Interviewed recovery coaches reported that the role is emotionally intense, and it is crucial to recognize that not everyone is ready to engage in recovery. Many program participants have mental health diagnoses and trauma, adding to the challenges faced by recovery coaches. One recovery coach struggled with implementing harm-reduction strategies in their area as people had misconceptions about the strategies and believed they were enabling behaviors.

> *They think if you're going to put a vending machine out there that contains needles, condoms, and things like that, you're enabling these behaviors basically … the people in town were like, "Nope, you're enabling the addict. You are telling them to have sex and things like that." It's not that at all. I'm trying to prevent an outbreak.*

Another recovery coach struggled with cultural differences between the program participants and himself, despite the organization's attempt at culturally responsive treatment.

> *For me personally, the big barrier here is a kind of a combination of age and culture. I am a 35-year-old pansexual, gender nonconforming, White dude. And the solid chunk of the community here is like the South Side, older Black gentlemen community. You know, a lot of people that I do try to reach out to and meet with and work with are older Black men in the ages of 45 to 70.*

While managing these challenges, recovery coaches continue to work on their own recovery and provide support for participants in the early stages of recovery.

All participating organizations have monitoring and oversight plans for recovery coaches.

Two participating organizations, Healing Action Network (Healing Action) and Recovery Corps, have implemented regular check-ins with their coaches to address self-care practices and vicarious trauma. These methods help identify potential issues before they significantly affect the coach's work. All participating organizations report that the organization provides opportunities for recovery coaches to connect with each other. This provides a mechanism through which struggling recovery coaches can get additional support to maintain their own recovery while still providing support to program participants. Recovery coaches report receiving support from other coaches and from leadership at their organization and that the support helped them to perform their job as a recovery coach.

Perceived Outcomes

Participating Organizations

Participating organizations reported improving organizational capacity to provide services, leveraging grant financial support, and collaborating with partners and community resources.

All participating organization directors reported in a survey that they agreed or strongly agreed that their programs have the organizational capacity to provide services. Interviews with project directors corroborated the survey results. Two participating organizations (Healing Action and AnB) reported services provided by AmeriCorps members expanded the organization's capacity to serve in rural areas, break down

communication barriers, and improve visibility in the community. Another participating organization noted that AmeriCorps members were critical to the process of scaling the organization's recovery program in three states.

All project directors also reported in a survey that they agreed or strongly agreed that their programs can leverage grant financial support. One project director stated in an interview that they would not have a program if it was not for support from AmeriCorps. The organization received a planning grant from AmeriCorps and then supplemented it with private funding.

Project directors also agreed or strongly agreed that their programs collaborate with partners, organizations, and community resources. As discussed above, all participating organizations worked with other organizations and/or providers in their area to facilitate client referrals for additional services.

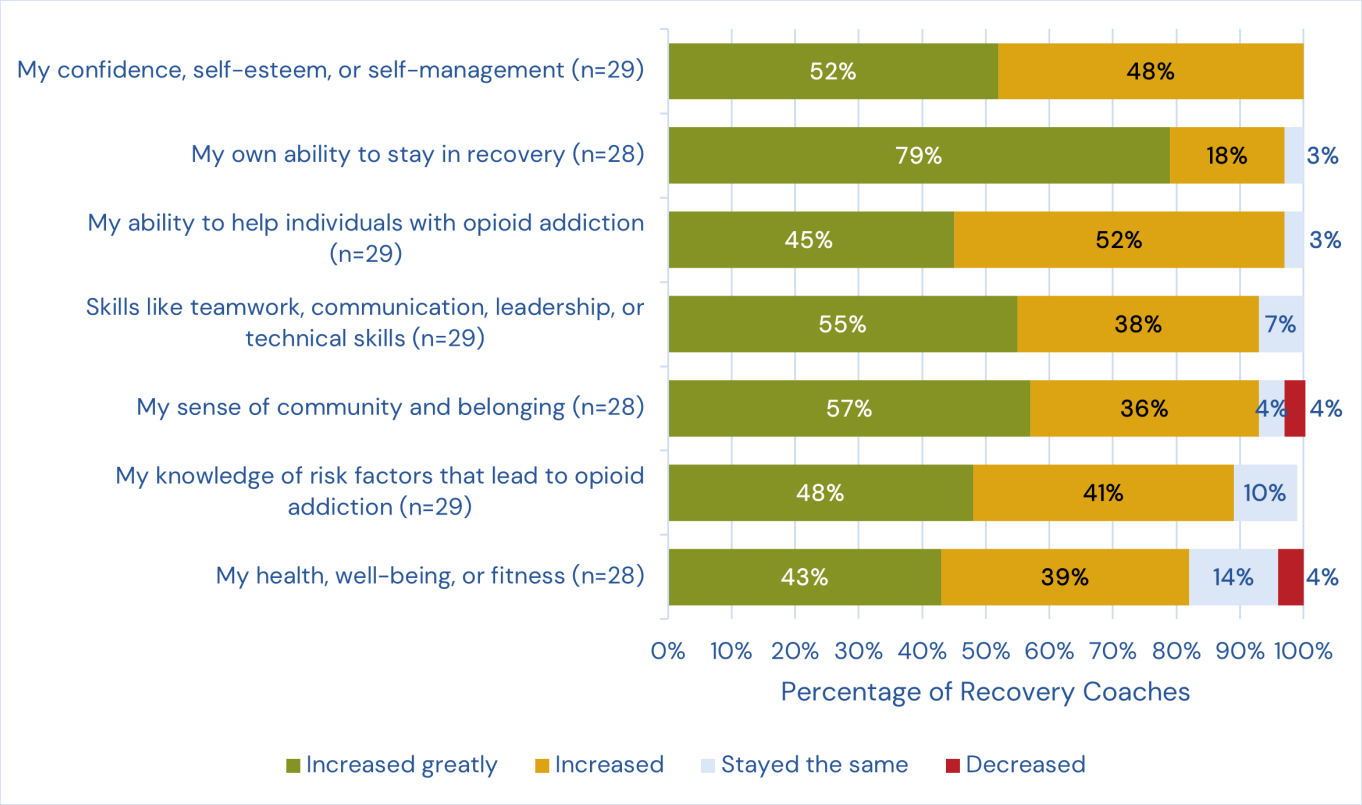
Recovery Coaches

Recovery coaches reported increased knowledge, improved attitudes, improved behaviors, and increased opportunities for maintaining their own recovery.

Recovery coaches rated their changes in knowledge, attitudes, and behaviors since becoming a coach (exhibit ES-4) on a 5-point scale (i.e., "increased greatly," "increased," "stayed the same," "decreased," or "decreased greatly"). Overall, the majority of recovery coaches reported increased (i.e., increased or greatly increased) knowledge, attitudes, and behaviors since becoming a coach:

- 100 percent reported increased confidence, self-esteem, or self-management;
- 97 percent reported increases in their own ability to stay in recovery;
- 97 percent reported increases in their ability to help individuals with opioid addiction;
- 93 percent reported increased skills such as teamwork, communication, leadership, or technical skills;
- 93 percent reported an increased sense of community and belonging;
- 89 percent reported increased knowledge of risk factors that lead to opioid addiction; and
- 82 percent reported increased health, well-being, or fitness.

EXHIBIT ES-4.—Recovery coach self-reported changes in knowledge, attitudes, and behaviors



Source: Recovery Coach Survey, question 24: "Please rate the following statements based on whether each factor has increased or decreased for you since becoming a recovery coach."
Note: Totals may not add up to 100 due to rounding. Not all survey respondents responded to each item in the survey, which accounts for an inconsistent number of responses to different items in the survey.

Recovery coaching plays a critical role for coaches to maintain their recovery. Recovery coaches serve as role models for program participants. One coach believes that being a coach has helped her reflect and maintain accountability in her recovery, stating, "I believe this job helps hold me accountable because if I am on the phone giving advice … I better be taking a hard look in the mirror and following my own advice." Another coach praised the coaching model, stating that it helps him stay in recovery and gives him a sense of purpose: "It's not just important for getting more people into recovery; it's so important for maintaining long-term recovery as well."

Program Participants

The short-term outcome of recovery coaching is increased recovery capital. Recovery capital includes an individual's internal and external resources that help to enhance capacity for, and commitment to, living a sober life. There are three types of recovery capital:

- **Family/Social** – Resources related to intimate relationships with friends and family, relationships with people in recovery, and supportive partners; also includes the availability of recovery-related social events.
- **Personal** – Includes an individual's physical and human capital. Physical capital comprises the available resources to fulfil a person's basic needs, such as their health, healthcare, financial resources, clothing, food, safe and habitable shelter, and transportation. Human capital relates to a person's abilities, skills,

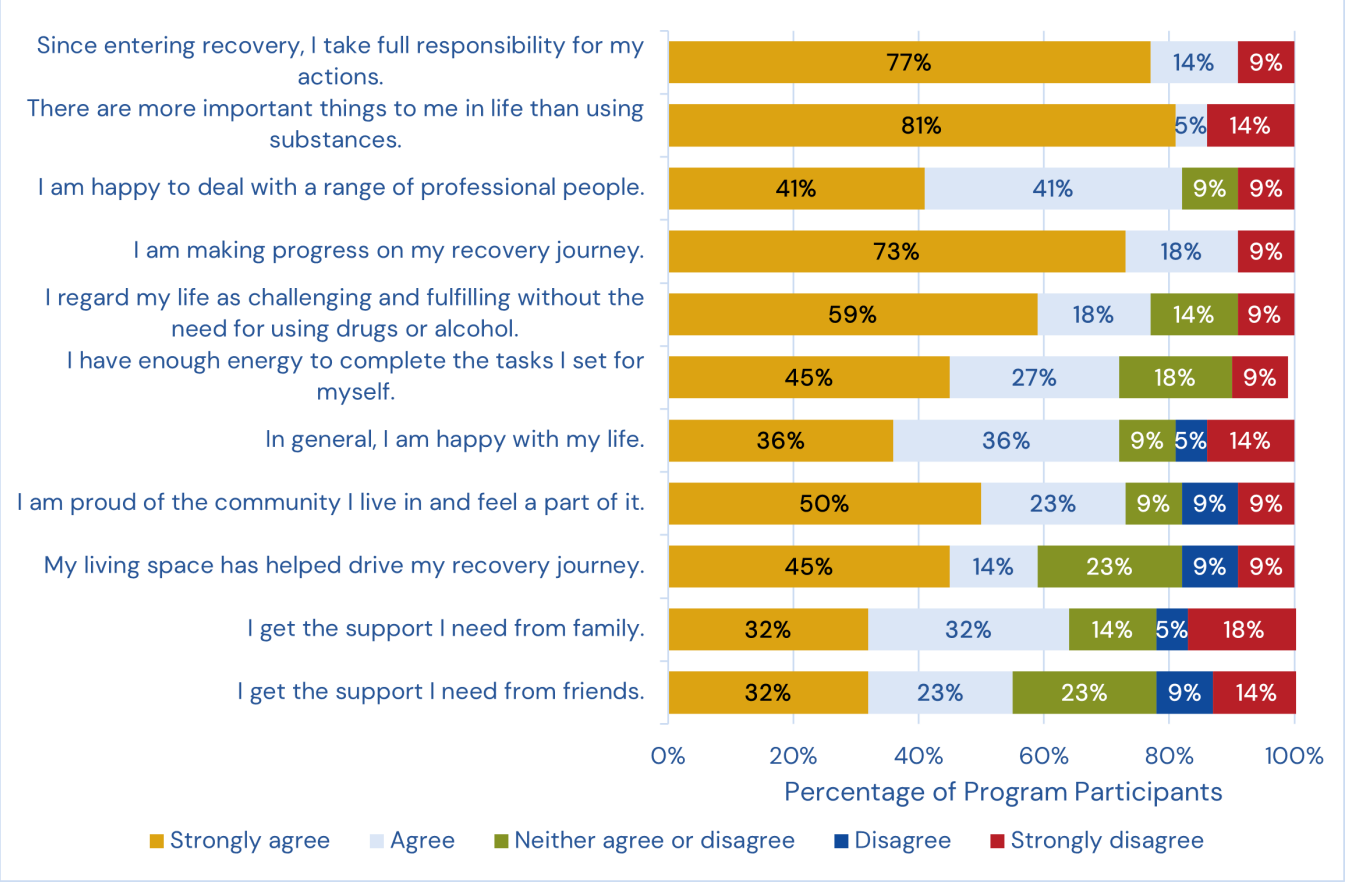
and knowledge, such as problem-solving, education and credentials, self-esteem, the ability to navigate challenging situations and achieve goals, interpersonal skills, and a sense of meaning and purpose in life.

- **Community/Cultural** – Community capital includes attitudes, policies, and resources specifically related to helping individuals resolve SUDs. Cultural capital includes resources that resonate with individuals' cultural and faith-based beliefs.

Program Participants reported high levels of recovery capital.

Survey items, adapted from the Brief Assessment of Recovery Capital (BARC-10; Vilsaint et al., 2017), measured the program participants' self-reported recovery capital on a 5-point scale ranging from strongly disagree to strongly agree. As illustrated in exhibit ES-5, program participants reported levels of agreement (including agree and strongly agree responses) of 50 percent or higher for all items. The highest levels of reported recovery capital among program participants were with the items "Since entering recovery, I take full responsibility for my actions" (91 percent); "There are more important things to me in life than using substances" (86 percent); "I am happy to deal with a range of professional people" (82 percent); and "I am making progress on my recovery journey" (91 percent). The lowest agreement was with the item "I get the support I need from friends" (55 percent).

EXHIBIT ES-5.—Program participant responses to recovery capital survey items



Source: Program Participant Survey
Note: Sample includes 22 responses out of the 35 program participants who participated in the survey. Totals may not add up to 100 due to rounding.

During the interviews and focus groups, the program participants shared the personal capital they gained through recovery coaching. The most frequently reported were gaining employment (4 participants), improved self-esteem (4 participants), improved quality of life (4 participants), increased ability to navigate challenges (3 participants), and increased knowledge (2 participants). They shared that recovery coaching taught structure and boundaries as well as how to love oneself in order to love others (2 participants). Other physical and human capital outcomes included improved health and housing (2 participants), feeling happy and hopeful again (2 participants), and healing (1 participant). Program participants also reported finding a community and having strong relationships since joining their recovery program (5 participants).

> *I came here and slowly but surely, I started to change. … And now I'm starting to come into confidence with myself and that was because I was watching other people here model that behavior. I got my family back, I moved into a home, and that's a wonderful thing.*
>
> *My quality of life has increased. I'm happier. I can problem-solve on my own. Sometimes I still need help problem-solving, but at least I know where to go to get help with my problems.*
>
> *I went back into a dark place in my life and I thank God for Above and Beyond because it was the people I had built relationships with here that reached out to me and called me and said I was worth saving.*

To understand what would happen in the absence of recovery coaching, the recovery capital outcomes of program participants were compared to comparison group members (exhibit ES-6). Mean scores for each recovery capital survey item indicate that program participants had higher agreement with all 11 recovery capital items, generally indicating greater recovery capital among program participants. Statistical testing used Mann-Whitney U tests to compare two independent groups (participant and comparison) with non-normal distributions of response data. Results showed marginal statistical significance (defined as p-value < 0.10) in between-group difference for three items ("I am proud of the community I live in and feel a part of it"; "Since entering recovery, I take full responsibility for my actions"; and "I am making progress on my recovery journey"). The small sample sizes warrant caution in interpreting these findings, and a deeper dive with more participants may be helpful to confirm the findings of the potential recovery capital benefits of recovery coaching.

EXHIBIT ES-6.—Differences between program participants and comparison group on mean scores for recovery capital survey items

Recovery Capital Survey Items	Participant Group (n=22)	Comparison Group (n=18)	Difference
There are more important things to me in life than using substances.	4.38	3.94	0.44
In general, I am happy with my life.	3.77	3.50	0.27
I have enough energy to complete the tasks I set for myself.	4.00	3.67	0.33
I am proud of the community I live in and feel a part of it.	3.95	3.22	0.73*
I get the support I need from friends.	3.50	2.94	0.56
I get the support I need from family.	3.55	3.44	0.10

Recovery Capital Survey Items	Participant Group (n=22)	Comparison Group (n=18)	Difference
I regard my life as challenging and fulfilling without the need for using drugs or alcohol.	4.18	3.72	0.46
My living space has helped drive my recovery journey.	3.77	3.27	0.49
Since entering recovery, I take full responsibility for my actions.	4.50	3.78	0.72*
I am happy to deal with a range of professional people.	4.04	3.72	0.32
I am making progress on my recovery journey.	4.45	3.67	0.79*

Source: Program Participant Survey and Comparison Group Survey
Note: Scale ranges from 1 (strongly disagree) to 5 (strongly agree). The comparison group was restricted to survey respondents who did not report getting recovery coach services.
* $p < .10$ from Mann-Whitney U test

To examine how recovery coaching changed participant behavior, the reported use of physical and/or behavioral health services was also compared between program participants and comparison group members. Larger percentages of program participants (45 percent) reported using services daily compared to comparison group members (28 percent). A larger percentage of comparison group members reported that they do not attend health services relative to program participants (28 percent versus 9 percent, respectively). However, the mean score difference between the two groups was not statistically significant, and the small sample sizes warrant caution in the interpretation of these results.

The final analysis compared reported use of opioids in the past 30 days. Out of 22 program participants, 17 (77 percent) reported never using opioids in the last 30 days, while 15 (83 percent) out of 18 comparison group members reported never using opioids in the last 30 days. Three program participants (14 percent) and two comparison group members (11 percent) reported using opioids at least once per day in the last 30 days. However, participating organization programs may offer harm-reduction services that include taking opioids for pain or withdrawal management, which could account for reported use of opioids in the past 30 days.

Evaluation Capacity Building

Evaluation capacity building was designed to complement the bundled evaluation in ways that support immediate and long-term evidence building for the recovery coaching model. First, in the short term, the evaluation capacity building helped participants stay engaged with the bundled evaluation. Every session included discussion prompts that encouraged participants to draw connections between evaluation concepts presented in the session and their own experiences participating in the bundled evaluation or other evidence building activities. Additionally, there were three sessions specifically designed to elicit participants' feedback on the bundled evaluation, such as their input on data collection activities in their context. By fostering participant engagement and feedback, evaluation capacity building strengthened the bundled evaluation and the evidence it produced. Second, the evaluation capacity building aimed to build participants' knowledge and confidence in evaluation topics, and thus empower participating organizations to generate future evidence on recovery coaching in the long term by planning and implementing evaluations in their own specific contexts going forward.

Evaluation capacity building was provided to bundle participants over the course of 12 technical assistance sessions of 1 hour delivered on a monthly basis.

The evaluation capacity building component was evaluated by a third party, BCT Partners, to assess participants' satisfaction with the sessions and assess participants' knowledge of and attitudes toward evaluation at the beginning and conclusion of the entire curriculum. A session-specific post-session survey was administered at the conclusion of each presentation. Results from these surveys were used to calculate a composite satisfaction rating on a 1–5 scale for each session and assess participants' knowledge of session content; key findings follow.

Participants liked the pairing of evaluation capacity building with the bundled evaluation, especially for the opportunities it provided to discuss their program challenges as well as opportunities for building evidence. In general, participants were very satisfied with the learning experience. All sessions had a mean satisfaction rating higher than 4 on a 1–5 scale, including 4 sessions for which all participants gave a satisfaction rating of 5: Preparing to Collect Data, Connection to the Bundle Evaluation, Evaluation Reporting, and Using Evaluation for Program Improvement and Continuous Learning. In open-ended responses, participants said evaluation capacity building included tangible content they could immediately apply in their context. They also liked the opportunities to interact with others working in this space, especially to discuss challenges and opportunities for building evidence in this space.

Participants increased their knowledge of evaluation topics and had more positive attitudes toward evaluation. Participants' perceived knowledge of evaluation topics increased across seven out of thirteen topics as measured on the pre-post survey. The topics for which participants' perceived knowledge increased the most included: recognizing what a theory of change is, recognizing how a theory of change connects to a logic model, and recognizing how quantitative and qualitative analysis is performed. On eight of the ten items measuring attitudes toward evaluation, changes from pre to post indicated more positive attitudes toward evaluation, with the largest positive change associated with the statement "Evaluation will inform decisions I make about my program."

Participants reported greater confidence in evaluation-related topics after the sessions. Participants reported more confidence in their ability to train their staff on evaluation topics and engage effectively with an external evaluator. Specifically, participants reported improved ability to know which questions to ask and how to write about evaluation findings.

Discussion

The implementation findings from this study corroborated the existing literature on recovery programs. The current study found that lived experience is a crucial pillar of all peer recovery coach models because it positively affects relationship building between peer recovery coaches and program participants, which can improve participant outcomes. This finding supports the growing research literature on successful traits of peer recovery coaches (Kawasaki et al., 2019; Zandniapour et al., 2020). A challenge associated with lived experience, however, is that having an SUD may have resulted in previous involvement with the criminal justice system, posing a potential barrier to hiring due to the criminal background check.

Program models and activities had common elements; however, the participating organizations provided individualized activities and services that were geared to the populations served and their respective settings. Treatment programs that are tailored to the individual are common among recovery coach programs, which aligns with literature that notes services vary due to the program setting and target populations (Eddie et al., 2019). State policies—from harm-reduction services to behavioral health services for Medicaid enrollees (Guth, 2021) and more—are also a contextual factor in shaping how and what services are delivered to participants in recovery coaching programs. While most of the existing research focuses on a recovery-

oriented culture (e.g., Chapman et al., 2018), studies that examined culturally appropriate services were not found. The current study provides new information on how recovery coaching programs implement culturally appropriate services into the organization and treatment plans for individuals.

This study found that participating organizations implemented recovery coach programs designed to meet the needs of the populations served and that participants had favorable perceptions of the recovery coach services. In addition, participating organizations, recovery coaches, and program participants reported favorable outcomes. Only a subset of recovery coaches and program participants participated in the study, however, so the findings should therefore not be considered representative of all recovery coaches or program participants at the participating organizations.

It would be valuable to know what the outcomes would be in the absence of recovery coaching. The study was designed to compare the outcomes of program participants and nonparticipants by recruiting a comparison group, but logistical limitations prevented robust investigation of a sizeable comparison group. One participating organization sent the survey link to individuals who did not receive any services from a recovery coach, and another provided the names of individuals who only met with a recovery coach once. There was a question on the comparison group survey that asked if the individual was receiving recovery coach services, and not all responses aligned with the list provided beforehand. Ultimately, respondents were classified as program participants (i.e., receiving recovery coaching services; n=22) or as part of the comparison group (i.e., not receiving recovery coaching services; n=18) based on their self-reported response to that question on the survey. The findings from the analysis suggested promising positive trends regarding the role of recovery coaching in increasing recovery capital for program participants. Future research involving a larger sample size to explore these findings more rigorously is therefore warranted.

This evaluation required collecting data from a vulnerable, hidden population (individuals with an SUD). In the recruitment calls at the start of the evaluation, staff from several AmeriCorps projects were hesitant to provide information because they wanted to protect the individuals being served. They did not want to share the names and contact information for their program participants and declined to participate in the evaluation. For those who agreed to participate, the survey was administered in multiple formats with a personalized identifier to protect the privacy of their program participants. Paper surveys were sent to one participating organization and survey links to other participating organizations. This resulted in a loss of information about the number of individuals who received the surveys and affected the ability to calculate response rates.

In addition, the response rates for the recovery coach and program participant surveys were low, and could not be accurately determined. The study team planned to collect data using a baseline survey and a follow-up survey 1 year later to compare changes in outcomes over time. The baseline survey was launched in November 2021 and remained open until March 2022. Reminders were sent; however, only 67.5 percent of recovery coaches and 32.6 percent of program participants completed the survey during the first wave. Due to low response rates, the follow-up survey was sent to all individuals rather than only those who completed the baseline survey. The response rate was still low, with only 28.1 percent of recovery coaches and 7.8 percent of program participants completing the survey in the second wave. However, these numbers do not account for the total number of surveys distributed directly by the participating organizations, and therefore, it is not possible to determine the overall survey response rate. Sample attrition and low response are known barriers in the substance use research space, and several challenges to this specific evaluation have been identified.

The necessity of recruiting participating organizations' help at the time of specific data collection procedures (e.g., baseline surveys) created a narrow channel for success; in addition to the confidentiality concerns, there was also deadline constraint to recruit and collect data via the project directors, putting them under pressure. Future evaluations can explore strategies to mitigate these limitations, for instance by creating opportunities to obtain informed consent directly from potential participants (e.g., program participants and recovery coaches). One strategy may be to conduct site visits in the early stages of organizations' participation that include information sessions for project directors, coaches, participants, and comparison group members about the evaluation—this can include promoting its value, its objectives, incentives for participation, and steps taken by study staff to ensure confidentiality and data security. Institutional Review Board approval can accommodate more open-ended recruitment strategies, for instance listing in the informed consent all potential study procedures (e.g., surveys, focus groups); that allows study staff to contact individuals for the specific study procedures that continue to apply on an individual basis. Giving potential participants early opportunities to become familiar with the evaluation, to provide informed consent, and to ask questions may increase study participation rates while also relieving the burden on project directors to administrate study procedures (e.g., distribute surveys). Alternatively, or complementarily, participating organizations can be provided with a simple information sheet to pass on to potential participants, and modern technology (e.g., QR codes) can allow potential participants to connect directly to study information and to contact study staff to express interest or to ask questions. Such steps to expose populations of focus in advance of study procedures may alleviate confidentiality and time concerns associated with relying upon project directors to recruit and collect data. In a similar vein, organizations' concerns about confidentiality may suggest the need to communicate more with project directors about the steps evaluators/AmeriCorps have in place to secure privacy (e.g., anonymizing any quotations used in reports, data security procedures). Quelling concerns about privacy and confidentiality may encourage more invested recruitment and tracking efforts. Finally, improved incentivization may motivate greater participation and response, which may entail compensation that is of greater monetary value or more germane to participants.

As noted, of the original eight organizations who agreed to participate in the evaluation, four organizations ultimately withdrew, either expressing concerns about maintaining the privacy of their program participants or providing no explicit reason for dropping out. The pandemic undoubtedly placed strain on organizations and likely hindered the ability of some organizations and individuals to fully participate in the evaluation process as they focused on delivering core services amidst evolving public health guidance.

The pandemic also affected data collection by the study team. In-person interviews and focus groups were planned at each site; however, due to the pandemic, virtual interviews and focus groups were ultimately conducted. It was also difficult to recruit participants for focus groups. Project directors were provided with a form letter to let the participants know that the study team would be reaching out to them about the focus groups. Still, program participants from only one organization participated in the focus group. Individual interviews were offered as another option (only one program participant accepted). Recovery coaches who participated in the interviews were asked if they would assist with recruiting program participants for interviews. Program participants were offered $25 Amazon gift cards for participation in a focus group or interview, yet feedback from one recovery coach suggested that a gift card would not be an incentive for her participants without internal motivation to participate.

Organization staff who participated in the evaluation capacity building sessions echoed some of the challenges faced by the evaluation team. In their sessions, they reported that their program models often pose data collection challenges, especially because their intended beneficiaries are often difficult to reach and reluctant to share information on a survey or in a focus group.

A key priority to further this work is rigorous measurement of program impact through recruitment of a valid comparison group (i.e., a subpopulation not receiving recovery coaching services). Well-established high attrition rates among study participants in substance use research, the intensive and acute nature of many recovery programs, and the high variability in treatment services provided across individuals and contexts all pose systematic barriers to rigorous research with comparison groups. An impact study was not possible in the current evaluation due to a lack of robust and/or statistically matched comparison group data, which stemmed from participating organizations' concerns with confidentiality as well as limited data tracking for individuals who were not receiving recovery coaching services. Future studies seeking to evaluate impact will require direct access to potential participant populations, enabling timely tracking of recruitment pools.

When assembling a comparison group for recovery coaching, access to individual-level data is important to maximize the potential for a rigorous comparison group that is engaged with substance use treatment but not with recovery coaching. To reduce confounding, researchers and participating organizations can work together to ensure data include covariates based on theory/literature, such as demographic characteristics and other treatment services received. Biases, such as self-selection bias or non-response bias can be considered with sampling approaches such as waitlist control or stratified random sampling. Alternately, analytical methodologies, such as dose-response modeling, may allow a more flexible approach when a strict comparison group is not possible.

Next Steps

Given the small sample size of data collected for this study and the challenges faced by the programs due to the pandemic, a second cohort of organizations will participate in the bundled evaluation and evaluation capacity building sessions. The cohort includes both AmeriCorps State and National grantees and AmeriCorps VISTA sponsors that received AmeriCorps funding in FY 2021 or FY 2022. Twelve organizations were invited to participate in the evaluation; nine accepted. As of October 2023, there are seven organizations participating in the evaluation.

Surveys for project directors, recovery coaches, AmeriCorps members, and program participants were launched in February 2023. Evaluation capacity building was launched with project directors in March 2023. Site visits occurred in fall 2023. The results from the Cohort 2 study will be aggregated with the current study, with the goal of generating more conclusive findings from a larger sample size.

In addition, ICF has partnered with one participating organization from the first cohort, Recovery Corps, to conduct additional analyses on a robust set of longitudinal administrative data collected by the organization on participants receiving support services from recovery navigators. Analyses will explore descriptive comparisons of site-level characteristics (e.g., case load) as well as statistical inference testing on hypotheses on the beneficial effects of support services and various outcomes.

With these findings, AmeriCorps will continue to build evidence on best practices for recovery programs and explore how the agency mitigates SUDs and supports recovery through AmeriCorps projects. The goal is that findings will help to set standards and to shape the course of future recovery programs and other similar types of programs.

Introduction

The United States is facing an unprecedented addiction and overdose epidemic. Drug overdoses have claimed over a million lives since 1999, with annual deaths increasing by 14 percent from 2020 to 2021 (Centers for Disease Control and Prevention[CDC], 2023a). The increased rate of overdoses and deaths is largely connected to increased prescription of opioid medications during the late 1990s, which led to widespread misuse of prescribed and nonprescribed opioids. More than 75 percent of all drug overdose deaths in 2021 involved opioids (CDC, 2023a). Moreover, opioid-related overdoses often involve other substances such as alcohol or psychostimulants, and polysubstance use can increase risk for overdose (CDC, 2023b). The coronavirus disease 2019 (COVID-19) global pandemic and the proliferation of synthetic opioids (e.g., fentanyl) and animal tranquilizers (e.g., xylazine) in many types of drugs has also accelerated drug overdose death rates (Substance Abuse and Mental Health Services Administration [SAMHSA], 2023, CDC, 2023c, 2023d, 2023e). Early research suggests public health measures such as mandatory stay-at-home orders contributed to unintended social, psychological, and economic consequences, all of which increase the risk of overdose (Tanz et al., 2022).

The mitigation of substance use disorder (SUD) prevalence and related mortality rates is an urgent public health priority in the United States. In 2017, the U.S. Department of Health and Human Services declared a public health emergency in response to the increasing number of opioid-related overdoses and deaths. President Biden has declared the administration's commitment to addressing addiction and the overdose epidemic (The White House, 2022), and the efforts of federal agencies such as AmeriCorps are critical to successfully undertake this national priority.

Due to differences in funding, policies, regulations, available resources, and the overall approach to addressing SUDs, substance use treatment and harm-reduction options[2] may vary across states. In general, for those seeking treatment, there are several major options involving a combination of medication assisted and non-medication assisted treatment approaches. Treatment involving medication assistance typically involves regular visits to treatment centers to receive doses of methadone, buprenorphine, or naltrexone. Contrary to popular belief, these medications do not simulate the chemical effects of opioids, but rather lessen urges and withdrawal symptoms to ease the recovery process (American Society of Addiction Medicine, 2016). The majority of medication assistance programs require participants to attend counseling services simultaneously.

As medication assisted treatment continues to become a key modality for substance use care (Gagne et al., 2018), the importance of providing supportive services for those beginning their journey through recovery cannot be understated. In response to the 2017 public health emergency declaration and growing demand for SUD treatment access, AmeriCorps increased its efforts to fund programs specifically targeting opioid addiction and other SUDs. One promising strategy to address the rising rates of SUDs and drug overdose is recovery coaching through AmeriCorps members.

[2] The Substance Abuse and Mental Health Services Administration (SAMHSA) defines harm reduction as "an approach that emphasizes engaging directly with people who use drugs to prevent overdose and infectious disease transmission, improve the physical, mental, and social well-being of those served, and offer low-threshold options for accessing substance use disorder treatment and other health care services." For more information, please see SAMHSA web page on harm reduction.

Recovery Coaching

Recovery coaching is the process in which a nonclinical professional with lived experience with an SUD provides guidance to individuals with an SUD by helping them access care and supporting them in the removal of barriers to recovery (Zandniapour et al., 2020). Recovery coaching is operationalized in this report to include recovery coaching by state-certified coaches as well as other forms of coaching and support provided by non-certified coaches, navigators, mentors, and support staff following a peer support services model for SUD recovery.

Since recovery coaches have similar backgrounds to individuals seeking treatment, the recovery process is reliably informed to support long-term recovery potential. The primary purpose of recovery coaches is to function in a support role and provide several different types of assistance, including:[3]

- Emotional support – listening, providing empathy, and showing concern
- Informational support – providing connections to information and referrals to community resources
- Instrumental support – providing concrete supports, such as for housing or employment
- Affiliational support – providing connections to recovery community supports, activities, and events

In contrast to other recovery approaches, the peer recovery coaching approach notably differs due to its use of lived experience. Coaches assist individuals seeking treatment by guiding the development of a recovery plan tailored to the strengths, needs, and goals of each individual to promote long-term recovery.

The services provided by recovery coaches are critical supports to individual recovery and reintegrating members into the larger community (Center for Substance Abuse Treatment, 2009). While clinical treatment programs provide vital, immediate support, recovery support services allow recovery to be an adaptable, tailored process to maximize long-term outcomes and to connect individuals to local, ongoing community supports. These supports help individuals progress toward building the resources required to begin and maintain recovery, also known as recovery capital (SAMHSA, 2017).

Prior Research on Recovery Coaching

In response to recognition from the broader recovery field regarding the need for long-term support, research on recovery coaching emerged in the early 2000s. To date, the majority of published literature within this topic uses quasi-experimental design or descriptive approaches such as combinations of qualitative, survey, and administrative data analysis. Few studies employ traditionally rigorous designs such as randomized controlled trials; however, previous systematic reviews note that these designs may not be suited to peer-based programs given the many settings in which they are delivered (Bassuk et al., 2016).

Common outcomes examined include substance use, housing stability, justice-involved status, mental and physical health, and uptake of services related to recovery from an SUD. Literature on recovery coaching typically focuses on the effect of individual support interventions on the common outcomes discussed above. It is important to note that the majority of recovery coaching programs and literature do not focus on one singular substance used by participants; many recovery support systems serve individuals seeking recovery from multiple substances.

In a spanning literature review on recovery support services in the United States completed by Massachusetts General Hospital and Harvard Medical School, peer-based recovery support services were identified as one of

[3] SAMHSA Peers Supporting Recovery from Mental Health Conditions web page

the six main types of recovery services offered (Eddie et al., 2019). Peer-based programming literature highlighted in the reviews noted that the services delivered varied due to the diversity of program settings and populations of focus. Additionally, across the literature, the time and frequency of service delivery vary according to the setting and needs of the service population. In line with the previous section's understanding of recovery coaching, common services provided by peer-based programs include the creation of individualized recovery plans, development of coping strategies, employment services, group support meetings, and referral to supports such as mental health services or housing assistance (Bassuk et al., 2016).

While it is difficult to compare the effect of interventions with widely differing offered services and delivery timing/frequency, common themes among the interventions examined include the importance of recovery coaches/workers providing holistic services, establishing trust through emotional support, and encouraging long-term recovery through an individual's participation in community supports (Bassuk et al., 2016).

Of the studies reviewed focusing on peer-driven support programs, interventions that were completely peer-driven generally led to overall increased physical and mental health well-being, decreased rates of relapse, and increased access to supportive services (Bassuk et al., 2016). While studies that aim to compare and contrast multiple peer-based recovery programs are scarce due to difficulty in generalizing findings, meaningful insights can still be drawn from the literature that examine peer-based treatment interventions.

A quasi-experimental study of adults with an SUD participating in a support community program found that participants felt an increased sense of support ranging from emotional, informational, and instrumental support following the intervention period (Boisvert et al., 2008). During the follow-up period, authors observed decreased relapse rates of support participants when compared to participants in the previous year who did not participate in support programming. In addition to overall decreases in relapse, longer durations spent in recovery programs have demonstrated longer durations of sobriety (Kamon & Turner, 2013).

When available, peer-recovery programs have also demonstrated successful outcomes in tandem with medication assisted treatment clinics. In partnership with clinics across Pennsylvania, recovery specialists with lived experience assisted program participants with transition from various care settings and referred participants to community support resources (Kawasaki et al., 2019). In this role, the recovery specialists functioned to remove barriers to medical-assisted and community care by organizing and providing transportation, appointment scheduling, patient advocacy, and establishing connections to peer-led support meetings. The study found that the addition of supportive recovery specialists reduced the timeline for medication assisted treatment patient intake appointments from 2 weeks to 24–48-hour turnaround times.

Numerous studies have found that people in recovery may prefer the treatment approach over traditionally-trained counselors. A study with pregnant and postpartum women in recovery from crack-cocaine addictions found that participants were more likely to identify peer-delivered services as empathetic, strong sources to learn about other resources offered by the clinic, and oftentimes were the most significant aspect of the counseling program (Sanders et al., 1998).

Similarly, a survey of students within college-based recovery programs revealed that participating students valued their peer-based programs for the ability to receive support/services from a similar age group. The study noted that a top reason listed for joining the program was the desire to maintain sobriety in a higher-risk environment, with approximately 33 percent of the sample claiming that they would not be attending university if they were not a part of the recovery program, further revealing the effect of peer-support approaches to maintain long-term recovery and increase favorable participant outcomes (Laudet et al., 2016).

AmeriCorps-Funded Recovery Coach Programs

Between fiscal year (FY) 2017 and FY 2022, AmeriCorps invested over $129 million to fund projects addressing opioid addiction and other SUDs. This investment includes the use of AmeriCorps members to deliver recovery coaching.

Within the more specific context of recovery coaching delivered by AmeriCorps-funded programs that employ national service members as recovery coaches, a report explored the successes and challenges of selected programs and the value added of the association with AmeriCorps (Zandniapour et al., 2020). The study explored 16 AmeriCorps-funded programs across the country that operate in a variety of settings such as clinical centers, hospitals, homeless shelters, and recovery/rehabilitation houses. The majority of recovery coaching programs focus on providing services to participants who are actively experiencing an opioid use disorder or the associated negative consequences. To assist these populations, common services provided within AmeriCorps-funded programs include the development of individualized treatment plans and establishing connections to additional resources within the community, which aligns with the broader literature on recovery approaches.

To document the perspectives of recovery coaches regarding the program, their specific role, and the effects of their service, the study presented overall highlights from interviews with staff from five out of the sixteen participating programs. These discussions revealed the significant importance of seeking applicants with lived experience to ensure the longevity and success of national service members in the recovery coach role.

As noted in the broader peer-based literature, the study authors observed that recovery coaches placed emphasis on the importance of sharing their own experience with an opioid use disorder to establish trust and credibility as a "peer." In addition to contributing to the recovery capital of program participants, interviews with recovery coaches revealed that sharing their experiences with an opioid use disorder was not only impactful for participants, but also a significant pillar of the long-term recovery of the coaches themselves.

In summary, the foundational report on using AmeriCorps funding to support recovery coaching programs contributed important insights into the organizational makeup and administration of 16 programs across the United States. The report recommended conducting a bundled "process and outcomes evaluation" of AmeriCorps-funded recovery coach programs—as well as an impact evaluation—to continue to build the evidence. The current study aims to build upon the general and AmeriCorps-specific evidence base surrounding recovery programs; services provided; and outcomes of participants, recovery coaches, and participating organizations implementing a recovery coaching approach.

Overview of the Study

AmeriCorps' mission to combat the complex issues around substance use prevention includes research and evaluation of promising treatment options. In 2020, AmeriCorps contracted with an independent consulting firm, ICF, to provide a comprehensive evaluation of AmeriCorps projects' use of recovery coaching models—which was initially focused on recovery from opioid use disorders but was later expanded to recovery from SUDs more broadly—to understand best practices for effective recovery coaching programs. This included bundling projects with similar programs and outcomes across AmeriCorps funding streams as well as providing participating organizations with evaluation capacity building sessions. By simultaneously growing the evidence base for national service, encompassing the entire program life cycle, and incorporating capacity

A Note on Terminology

The term "recovery coach" is used throughout this report for ease of interpretation and refers to individuals with may have lived experience with an SUD working in or providing navigation services in the recovery space. That said, the terms used for recovery coaches varied by participating organization and were often based on the state term and state certification for the role. Additional details on terms used by each organization may be found in exhibit 2-1 in Chapter 2.

Further, the study's focus on "recovery coaching" was intentionally designed to cover the greatest variety of recovery coaching-type models used by organizations with AmeriCorps projects, based on a review of project applications and consultation with subject matter experts. Given that "recovery coaches" are often state-certified positions and not all organizations in the study had certified recovery coaches delivering services, the term is used in this report to be inclusive of the range of models, including those with "peer navigators," "peer support specialists," etc.

building and dissemination activities, this project seeks to enable AmeriCorps to more effectively support locally driven and innovative solutions for communities seeking to address SUDs.

As a framework to guide the study, a logic model (see Appendix A) was developed based on a document review of several recovery coach programs. The logic model outlines the relationships between recovery coach interventions and activities; expected outputs; and their desired short-, intermediate-, and long-term outcomes. The logic model is comprehensive, covering a broad list of strategies across all related models rather than representing strategies from any specific models. The logic model specifies the connections between components of the models (i.e., the relationships between strategies and results or outputs and outcomes), and the relationships within the components (i.e., how strategies employed by participating organizations will influence those employed by recovery coaches and subsequently the program participants).

Research Questions

This evaluation focuses on three overarching research objectives: 1) to determine what recovery coaching models look like; 2) to describe promising practices and challenges in implementing recovery coaching models; and 3) to measure the effectiveness of the recovery coaching model in improving outcomes for the organizations, recovery coaches, and program participants (also referred to as "clients"). These overarching objectives are broken down into implementation and outcome research questions.

Implementation Questions

- How do organizations recruit and work with recovery coaches to provide the service?
- How do organizations work with partners to help program participants fill in the gaps of their holistic treatment plans?
- What kinds of support do organizations provide in program monitoring and tracking (e.g., outreach, enrollment, referrals/connections to services, etc.)?

- To what extent are participating organizations able to leverage additional resources to support their programs?
- What types of activities do recovery coaches engage in and what is the setting, modality, frequency, intensity, and duration of the services they provide?
- What are recovery coaches' experiences in interacting with participating organizations and program participants? What are the successes and challenges?

Outcome Questions

- To what extent do participating organizations demonstrate an increased organizational capacity to provide service?
- To what extent do participating organizations demonstrate an increased ability to leverage grant (i.e., financial) support?
- To what extent do participating organizations increase their collaboration with partners and community resources?
- To what extent do recovery coaches improve knowledge, attitudes, and behaviors?
- To what extent do program participants improve their recovery capital as a result of participation in recovery coaching?
- To what extent do program participants increase attendance to physical and behavioral health services because of participation in recovery coaching?
- To what extent do program participants experience a decrease in substance use because of participation in recovery coaching?

Organization of This Report

Chapter 2 details the methodology used for this study, including the evaluation design, the data sources, and the analysis methods. Chapter 3 presents the results obtained and key findings about the recovery coach programs (program models; activities and services provided; the identification, recruitment, and training of recovery coaches; and program monitoring). Chapter 4 presents the findings related to recovery coaching activities (support; duration and intensity of services; and referrals to other supportive services). Chapter 5 presents the results of the analyses of the outcomes for each group (participating organizations, recovery coaches, and program participants). Chapter 6 presents findings on the evaluation capacity building services provided to participating organizations. The report concludes with a discussion of the study findings and next steps (Chapter 7). The appendices contain information about the data collection instruments. They also contain additional information about the participating organizations and state certification requirements for recovery coaches.

Methods and Data Sources

This chapter describes the evaluation design including the approach used to select AmeriCorps projects for the study. Next, the study sample, data sources, and data collection methods are described. The chapter explains the analytic approach and concludes with a discussion of the limitations of the methods and data sources.

Evaluation Design

The evaluation used a bundling approach by pooling AmeriCorps projects with similar programs and outcomes across AmeriCorps funding streams. Analyses were conducted using a mixed methods approach to examine the implementation of recovery coaching models across different participating organizations and the outcomes for organizations, recovery coaches, and program participants. Information from interviews, focus groups, and program documents were collected and synthesized to provide a narrative description of how the participating organizations implemented their programs. Successes, challenges, and lessons learned were identified. The original plan for analyzing outcomes was to assess the changes between baseline and 12-month follow-up survey data for participating organizations, recovery coaches, and program participants and conduct an impact analysis using program participant and comparison group surveys. However, sample sizes were too small to allow for these analyses (this is discussed later in the chapter).

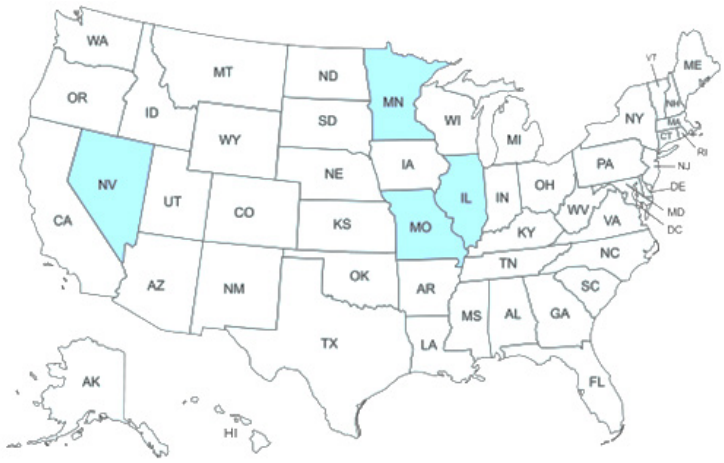
Study Sites

In spring 2021, the AmeriCorps project selection process began with a review of documents, including project applications from an earlier study by AmeriCorps' Office of Research and Evaluation (Zandniapour et al., 2020) that drew on FY 2017–18 projects. AmeriCorps provided 17 project applications from FY 2020 to the contractor. This included AmeriCorps State and National and AmeriCorps VISTA projects. Under AmeriCorps State and National, organizations leverage the use of AmeriCorps members to help them address a community need. Under AmeriCorps VISTA, organizations sponsor individuals (i.e., VISTAs) to create or expand programs designed to empower individuals and communities to overcome poverty. The evaluation team reviewed the applications of organizations that were active in FY 2021 for terms such as "peer recovery coach," "recovery coach," and "opioid." From project applications, organizations' use of a recovery coaching model as well as organizations' unique structures, approaches, and populations served were assessed. The points of contact in the project application were invited to participate in the bundled evaluation. Recruitment calls were conducted with interested organizations to tell them more about the planned evaluation activities and to assess if they had a potential comparison group (i.e., individuals who received services at the organization but did not work with a recovery coach). After organization recruitment calls, some organizations provided additional documents on their programs, which were used to further assess relevance to the bundled evaluation.

Several organizations declined to participate in the study due to concerns about protecting the confidentiality of the individuals being served. Initially, eight organizations agreed to participate, but four organizations withdrew from the study in the months that followed. Two of the organizations that eventually withdrew from the study participated in some early evaluation activities, including the initial wave of surveys and early sessions from the evaluation capacity building component. Studying this population is very challenging, as demonstrated by the loss of four participating organizations. While some organizations expressed concern about maintaining the privacy of their program participants, others simply dropped out without a stated reason. The COVID-19 pandemic further hindered the ability of some organizations and individuals to fully participate in the evaluation process as they pivoted to adapt their programs to meet changing public health

guidance. Ultimately, the final sample included the following four organizations—three AmeriCorps State and National grantees and one AmeriCorps VISTA sponsor—located in Illinois, Minnesota, Missouri, and Nevada:

- **Above and Beyond Family Recovery Center (AnB)**. AnB provides addiction recovery services to all individuals, including those who are unable to pay for them. In addition to recovery services, AnB offers supportive services, such as housing and employment assistance. Based in Illinois, AnB serves clients from Chicago and neighboring suburbs, with most clients coming from Chicago's west side. AnB's population of focus are low-income individuals and communities including individuals and families experiencing homelessness, unemployed individuals, individuals with disabilities, formerly incarcerated adults, veterans, and military families. Many of the participants are chronically homeless as defined by the U.S. Department of Housing and Urban Development (2015). As an AmeriCorps VISTA sponsor, the VISTAs at AnB did not provide recovery coaching services; instead, they supported project management and capacity building services related to housing and employment, community outreach, and education. Individuals delivering coaching services, "certified peer recovery support specialists," were paid staff.
- **Foundation for Recovery (FFR).** Based in Nevada, FFR provides recovery support services for mental health and SUD recovery to vulnerable teenaged and adult populations. FFR targets individuals in detention centers, jails, and emergency room departments, and in underserved areas with nonexistent or extremely limited services (such as rural and frontier communities). As an AmeriCorps State and National grantee, FFR had members serve as "recovery navigators," delivering similar recovery support services and receiving the same training as the organization's coaches who were paid employees (i.e., "peer recovery support specialists").



- **Healing Action Network (Healing Action).** Healing Action provides access to preventative mental health services through case management, opioid education, therapeutic counseling, peer support, and community education to St. Louis, Mo., and surrounding areas. Healing Action's population of focus is adult survivors of commercial sexual exploitation, which includes sex trafficking, prostitution, survival sex, escorting, stripping, and pornography. Most clients have experienced complex, multilayered trauma and have one or more mental health diagnoses. As an AmeriCorps State and National grantee, Healing Action had AmeriCorps members provide case management, opioid education and naloxone distribution, therapeutic counseling, and community education. Healing Action did not have AmeriCorps members delivering recovery coaching services; instead those services were provided by "peer support specialists" with lived experience with SUDs and trafficking.
- **Recovery Corps** works with organizations in Minnesota and Illinois that serve teens and adults in recovery for various types of SUDs. Recovery navigators provide peer support to assist those in recovery in achieving their goals and increasing recovery capital. Recovery navigators are placed in multiple organizations, including recovery residence associations, recovery community organizations, treatment facilities, collegiate recovery organizations, and recovery high schools. As an AmeriCorps State and National grantee, AmeriCorps members served as either recovery navigators, delivering peer

support and recovery coaching services, or opioid response project coordinators. The members additionally helped leverage volunteers to engage them in service projects to better support and connect with their surrounding communities.

Additional information about each participating organization is presented in Appendix B.

Terminology

In the absence of a universal definition for a recovery coach, the operational definition includes peer (i.e., share similar characteristics) and lived experience (i.e., similar life circumstances). The terms for recovery coaches varied by organization and were often based on the state term and state certification for the role (exhibit 2-1). For the purposes of this report, the term "recovery coach" is used throughout.

EXHIBIT 2-1.—Organization-specific terms for recovery coaches

Participating Organization	Recovery Coach Title
Above and Beyond (AnB)	Certified Peer Recovery Specialist (CPRS) and Certified Recovery Support Specialist (CRSS)
Foundation for Recovery (FFR)	Recovery Navigators (role of AmeriCorps Members) Peer Recovery Support Specialist (paid employee position)
Healing Action Network (Healing Action)	Peer Coach
Recovery Corps	Recovery Navigators

Data Sources and Data Collection

This study had three data sources: 1) participating organization program documents; 2) surveys of key organization informant groups; and 3) virtual site visits with the four participating organizations. Each data source and data collection procedures are described below.

Program Documents

In addition to project applications, the team collected program documents from the participating organizations during the virtual site visits. This included program operations manuals, employee handbooks, marketing materials (e.g., flyers for services and activities), and data analyses and reports.

Surveys

Survey protocols for project directors/managers, recovery coaches, program participants, and comparison group members were developed to understand program models and strategies and to assess program implementation and respective outcomes (see Appendix C). The protocols were customized to each participating organization (e.g., including the name of the organization in the survey).

- **Project director/manager surveys** assessed organizational capacity, staff recruitment, ability to leverage grant financial support, and collaboration with partners and community resources. One participating organization (AnB) had an AmeriCorps VISTA project and AmeriCorps members cannot provide direct recovery coach services. At the time of the study, AnB worked with a partner organization (Harmony, Hope, and Healing) to provide recovery coaching services to their clients. Therefore, the partner also completed the project director/manager survey.
- **Recovery coach surveys** assessed knowledge, attitudes, and behaviors; activities and services provided; experiences with the participating organizations; and experiences with program participants.

One participating organization (AnB) had AmeriCorps members assist with capacity building. Since capacity building was a key outcome for participating organizations, the survey also included items for AmeriCorps members. The recovery coach survey was modified to collect information from AmeriCorps members using skip logic (a feature in surveys that displays specific items based on a response to a previous item).

- **Program participant and comparison group surveys** assessed recovery capital, attendance to physical and behavioral health services, incidence of substance use, and experiences interacting with participating organizations and recovery coaches.

The study team launched two waves of survey data collection. The first wave was between November 2021 and March 2022 (i.e., baseline survey) and the second wave was between November 2022 and January 2023 (i.e., follow-up survey). Web-based surveys were administered using email addresses provided by sites. The names and email addresses for recovery coaches, program participants, and comparison group members were collected from the participating organizations. The original plan was to launch a baseline survey and a follow-up survey 1 year later to capture changes in outcomes. The follow-up surveys would only be sent to individuals who completed the baseline survey, but due to low response rates, the follow-up (second wave) survey was sent to all contacts. Also, the data collection strategy for the program participant survey changed due to the needs of the participating organizations.

- AnB works with individuals experiencing homelessness and the program participants did not have access to a computer or cell phone to complete the survey. A paper version of the program participant survey was created for this organization and was administered to program participants directly by the organization's partner. Once completed, the partner returned the surveys to the study team via mail. To have a means to capture baseline and follow-up data, an item to create an identifier based on the first three letters of their first name followed by the numerical day of their birthday was included. There was no available comparison group for this organization since all individuals receive recovery coaching. This organization participated in the first wave of survey data collection only.
- Healing Action works with victims of human trafficking and sexual exploitation. The organization was hesitant to share contact information for the program participants. Survey links that could be shared with the program participants and potential comparison group members were sent to the project director. This survey also included an identifier to help track baseline and follow-up responses. Healing Action was able to provide a comparison group of individuals who did not receive recovery coaching. This organization participated in both waves of data collection.
- Recovery Corps provided the names and contact information for program participants. The organization also provided a comparison group of individuals who only participated in one recovery coaching session. This organization participated in both waves of data collection.
- FFR had a planning grant and was not ready for the first wave of data collection. This organization participated in the second wave of survey data collection only. Survey links that could be shared with the program participants and comparison group members were sent to the project director.

Comparison group respondents were given $25 Amazon gift cards as compensation for their time. No other respondent groups were incentivized.

Exhibit 2-2 presents the number of respondents per survey by participating organization. Only one AmeriCorps member from AnB completed the survey.

EXHIBIT 2-2.—Number of surveys completed for each key informant group by participating organization

Participating Organization	Director/ Manager	Recovery Coach	Program Participant	Comparison Group
Above and Beyond (AnB)	2	5	2	12
Foundation for Recovery (FFR)	2	6	2	0
Healing Action Network (Healing Action)	1	1	4	2
Recovery Corps	1	29	14	4
Total	**6**	**41**	**22**	**18**

Note: Director/manager respondents include one program partner (AnB). Also, there was a director change at FFR, with one director completing the survey during the first wave and the other during the second wave. One recovery coach, four program participants, and two comparison group members answered yes to the consent statement but did not complete the survey.

Response rates could only be calculated for surveys that were sent directly by ICF to the participants. The response rate for recovery coaches was 67.5 percent in the first wave and 32.6 percent in the second wave. Ten recovery coaches had surveys in both waves of data collection. For program participants, the response rate was 20.8 percent in the first wave and 7.8 percent in the second wave. The response rate for comparison group members was 28.1 percent in the first wave and 17.2 percent in the second wave.

Survey Sample

Exhibit 2-3 presents the demographic characteristics for the survey respondent groups. Over half of recovery coaches (60 percent) were women and were White (60 percent), and most were non-Hispanic (89 percent). The majority of recovery coaches (81 percent) were between the ages of 30 and 59. Over 20 percent of recovery coaches were college graduates and 46 percent had some college/technical school. Almost one-third of the program participant survey sample—which stemmed from all four participating organization sites—were women (32 percent), over two-thirds were White (68 percent), and most identified as non-Hispanic (86 percent). Over half of the program participants (59 percent) were between the ages of 30 and 49 and the majority had a high school diploma or above (82 percent). The comparison group sample—which stemmed from just two participating organization sites—was predominantly White (44 percent) and male (39 percent), and largely identified as non-Hispanic (67 percent). The majority of comparison group participants were between the ages of 30 and 49 (45 percent) and had a high school diploma or above (56 percent).

EXHIBIT 2-3.—Demographic characteristics of recovery coaches, program participants, and comparison group members (reported in percentages)

Characteristics	Recovery Coaches	Program Participants	Comparison Group
Age	n=37	n=22	n=18
18–29 years old	13.5	18.2	0
30–39 years old	27.0	22.7	27.8
40–49 years old	29.7	36.4	16.7
50–59 years old	24.3	9.1	38.9
60–69 years old	2.7	4.6	16.7

Characteristics	Recovery Coaches	Program Participants	Comparison Group
70–79 years old	2.7	0	0
Gender	n=37	n=19	n=17
Male (including transgender men)	29.7	27.3	38.9
Female (including transgender women)	59.5	31.8	33.3
Nonbinary/nonconforming	2.7	4.6	0
Prefer to self-describe	5.4	22.7	5.6
Prefer not to say	2.7	0	16.7
Race	n=37	n=19	n=18
American Indian or Alaska Native	5.4	0	0
Asian or Pacific Islander	0	4.6	0
Black or African American	24.3	9.1	22.2
White	59.5	68.2	44.4
Other (please specify)	4.9	4.6	5.6
Prefer not to say	4.9	0	16.7
Multiracial*	0	0	11.1
Hispanic	n=37	n=19	n=18
Yes	2.7	0	16.7
No	89.2	86.4	66.7
Don't know	0	0	11.1
Prefer not to say	8.1	0	5.6
Highest grade completed	n = 37	n = 19	n = 18
Some high school	0	4.6	27.8
High school graduate or equivalent	32.4	27.3	5.6
Some college or technical school	45.9	36.4	44.4
College graduate	21.6	18.2	5.6
Prefer not to say	0	0	16.7

Note: Totals may not add up to 100 due to rounding.
* Online survey respondents were only able to select one race; the multiracial category includes paper survey respondents who selected more than one race.

Virtual site visits

The study team was unable to conduct in-person site visits due to the COVID-19 pandemic. Virtual site visits were conducted with all four participating organizations from May through June 2022. The site visits consisted of 90-minute in-depth interviews with participating organization project directors; 60-minute in-depth interviews with recovery coaches; 30-minute structured interviews with partner organizations and AmeriCorps members; and 60-minute focus groups with program participants. Due to the difficulty of recruiting program participants for focus groups, 30-minute individual interviews were also conducted with program participants. To increase participation rates, program participants were given $25 Amazon gift cards.

Evaluation Context: COVID-19

Grantees shifted programming to reflect public health guidance, causing some to struggle to adapt their programs. As a result, some grantees left the study. Remaining grantees noted the negative effect the pandemic had on participants in their respective programs.

Each site nominated program staff (including AmeriCorps members), recovery coaches, and program participants for interviews/focus groups. While participation from all four sites was invited and encouraged, the study team was unable to speak with program participants at Recovery Corps or FFR. Exhibit 2-4 provides sample sizes for interviews and focus groups.

EXHIBIT 2-4.—Number of interviews/focus groups completed for each key informant group by participating organization

Participating Organization	Project Director	Recovery Coach	AmeriCorps Member	Program Partner	Program Participant
Above and Beyond (AnB)	1	1	1	1	11
Foundation for Recovery (FFR)	2	1	N/A	1	0
Healing Action Network (Healing Action)	1	1	3	1	1
Recovery Corps	1	2	0	0	0
Total	**5**	**5**	**4**	**3**	**12**

Note: N/A = not applicable. A joint interview was conducted with the acting project director and the incoming project director at FFR. An external partner of AnB and internal partners of FFR and Healing Action were interviewed.

At the beginning of each interview/focus group, research staff reviewed the consent statement that was provided in advance. The consent statement included the purpose and content of the interview, the participant's rights, confidentiality, and data security practices. The research staff then obtained the interviewee's informed consent (including consent to record the interview/focus group). Interviews and the focus groups were guided by questions in the protocol as well as probes to facilitate discussion (see Appendix D). Interviewees were asked to describe in greater depth topics related to implementation, successes, challenges, and recommendations for program enhancements. The interviews and focus groups were conducted using Microsoft Teams (and audio recording).

Outcome Measures

The study focused on outcome measures for participating organizations, recovery coaches, and program participants. Each outcome was operationalized into indicators that informed protocol development (see exhibit 2-5).

EXHIBIT 2-5.—Outcomes and indicators

Outcomes	Indicators
Participating Organizations	
Increased organizational capacity to provide services	Participating organizations' self-reported organizational capacity
Increased ability to leverage grant financial support	• Participating organizations' self-reported ability to leverage resources • Participating organizations' receipt of funding or resources
Increased collaboration with partners and community resources	• The percentage of participating organizations that work with partners and community resources • Participating organizations' self-reported ability to collaborate with partners, organizations, and community resources
Recovery Coaches	
Increased knowledge, attitudes, and behaviors	Self-reported increase in knowledge, attitudes, and behaviors
Increased opportunity of maintaining their own recovery	Self-reported increase in recovery coaches' ability to stay in recovery
Program Participants	
Increased recovery capital	Rating by program participants on three dimensions: • Social capital (e.g., family support, social mobility, healthy lifestyle) • Personal capital (e.g., general health, employment, financial well-being) • Cultural capital (e.g., sense of purpose, sense of community values, spirituality)
Increased attendance to more physical and behavioral health services	The percentage of program participants who report increased participation in health- and mental health-related activities
Decreased incidence of substance use	The percentage of program participants who report they are not using opioids

Analysis

Survey responses from both waves of survey data collection were analyzed using IBM SPSS Statistics and R software. In the case of duplicate survey responses, the study team used the most recent response. As a result, some original, incomplete responses were dropped. If a respondent completed both the baseline and follow-up survey, the follow-up response was included in reporting of aggregate numbers. Due to the small sample sizes, all quantitative analyses used pooled data from the four participating organizations. Analyses included basic descriptive statistics, including means, standard deviations, and percentages. Subgroup

differences by gender, age, and race/ethnicity were not conducted due to small sample sizes. Changes in outcomes between baseline and follow up were not explored due to low survey response rates. Outcomes between the program participants and the comparison group were compared. Due to small sample sizes and non-normal response distributions, nonparametric tests of significance were conducted using Mann-Whitney U tests.

Interviews and focus groups were audio-recorded and transcribed for analysis. The transcripts were analyzed based on a codebook the study team developed. The codebook allowed the team to ensure that data accurately captured the underlying themes depicted in the program's logic model as well as the successes and challenges. The codebook contains fields that further describe each code, such as the code definition, and inclusion or exclusion criteria. All qualitative data were indexed and coded for descriptive and thematic analyses using NVivo data analysis software. Interpretive analyses tested the research questions and examined the relationships between the elements of the program models. The themes that emerged most consistently—as well as themes that are less consistent but noteworthy—were identified.

Limitations

This study provides important information for understanding how AmeriCorps projects provided recovery coaching services. However, several limitations were identified that readers should be aware of when interpreting the findings.

The study team interviewed a subset of recovery coaches and program participants. The study team did not interview all recovery coaches or program participants at each participating organization. The study team only interviewed a subset of recovery coaches who agreed to participate in an interview as well as a subset of program participants who agreed to participate in a focus group or interview. The team was only able to interview one external program partner at one site. Therefore, the findings presented in this report should not be considered representative of all recovery coaches, program participants, or program partners.

The response rates for the recovery coach and program participant surveys were low. The study team planned to collect data using a baseline survey and a follow-up survey 1 year later. The baseline survey was launched in November 2021 and remained open until March 2022. It was not possible to accurately determine response rates due to heterogeneity of survey distribution methods; for instance, some participating organizations' project directors preferred to directly distribute electronic surveys using general (i.e., untraced) links, and some participating organizations used paper-based surveys, and in both instances the total number of distributed surveys was unknown. Among the surveys distributed by the study team, the response was low with only 67.5 percent of recovery coaches and 32.6 percent of program participants completing the survey despite reminders to complete surveys. Due to the low response rates, the study team decided to send the follow-up survey to all individuals rather than solely those who completed the baseline survey. The response rate was still low, with only 28.1 percent of recovery coaches and 7.8 percent of program participants completing the survey, but these figures only account for surveys distributed by study staff and response rates for the total sample across all participating organizations are unknown. In addition, only 10 recovery coaches and no program participants completed both the baseline and follow-up surveys.

Data collection was affected by the COVID-19 pandemic. The study team planned to conduct in-person interviews and focus groups at each site. However, due to the pandemic, the team conducted virtual interviews and focus groups. This resulted in conducting only one focus group with program participants. The study team attempted to conduct virtual interviews instead, but it was difficult to connect with program participants.

The comparison group may have had access to recovery coaching services. The study used a survey in which participants self-reported services received, including recovery coaching services. Based on their response, participants were assigned to the program participant or comparison group for between-group analyses. It is possible that participants may not have exhaustively listed services received, and under-reporting of recovery coaching may have occurred. Similarly, analyses are unable to determine the timing and duration of services received (i.e., when the services were accessed, and for how long).

This study describes the implementation of the recovery coach programs by selected AmeriCorps projects and the self-reported outcomes of program participants. It does not establish causality between recovery coach programs and participant outcomes.

Recovery Coach Programs

This chapter describes the recovery coaching models and the activities and services provided by the participating organizations. It includes the process for recruiting and training recovery coaches as well as the processes for monitoring and tracking both recovery coaches and program participants. It also documents how the programs work with partners to fill in programmatic gaps as well as leveraging resources to support the programs.

Recovery Coaching Models

While the four participating organization program models are unique to the needs of their participants and the communities they serve, the programs have commonalities. All programs treat individuals with SUDs and use a peer support model. Recovery programming includes lived experience, cultural competence, harm reduction, and holistic care. Following is a description of the key components of the recovery coaching models, beginning with the participants being served.

Participants Served

While all participating organizations served individuals with SUDs, the populations of focus for each program varied across organizations and included individuals who experienced sexual exploitation or human trafficking, justice involvement, or homelessness.

- **AnB**'s population of focus are low-income individuals and communities including individuals and families experiencing homelessness, unemployed individuals, individuals with disabilities, formerly incarcerated adults, veterans, and military families. Many of the participants are chronically homeless as defined by the U.S. Department of Housing and Urban Development.
- **FFR**'s population of focus includes vulnerable populations (teens and adults) and provides services to individuals in detention centers, jails, and emergency room departments. They work with individuals in underserved areas with nonexistent or extremely limited recovery support services.
- **Healing Action**'s population of focus are adult survivors of commercial sexual exploitation, which includes sex trafficking, prostitution, survival sex, escorting, stripping, and pornography. Most clients have experienced complex, multilayered trauma and have one or more mental health diagnoses.
- **Recovery Corps**' population of focus are teens and adults in recovery from SUDs. Recovery Corps works with organizations that serve people in recovery, including recovery residence associations, recovery community organizations, treatment facilities, collegiate recovery organizations, and recovery high schools.

Peer Recovery Models and Lived Experience

All participating organizations used **peer recovery models** and required the peer recovery coaches and individuals in the process of getting certified as peer recovery coaches to have lived experience and to be in recovery.[4] **Lived experience was a pillar of all organizations' coaching models.** A director noted that lived experience was the most important qualification for peer recovery coaches and they would not hire a coach who was not in recovery. Another interviewee stated that lived experience provides authenticity for the recovery coaches. One organization (Healing Action) required their recovery coaches to have lived experience with both commercial sexual exploitation and substance use.

[4] One recovery coach described themself as in mental health recovery, not substance use recovery.

Survey respondents expressed the importance of lived experience. All project directors reported that having lived experience being in recovery was "very important" for recovery coaches. Among recovery coaches, 86 percent reported that lived experience affects relationship building with their clients/peers. In fact, 61 percent of recovery coaches reported that their own lived experience or recovery motivated them to become a recovery coach.

> *You can have all the training in the world, but without lived experience, you won't be able to fully relate to clients.*
>
> AmeriCorps member

Site visit participants echoed the importance of lived experience. All recovery coaches stated that having lived experience helps them in their work. The recovery coaches identified having empathy and having experienced challenges similar to the participants' as important. One recovery coach noted that active addiction is "a very lonely place," so lived experience makes communication and progress possible. Program participants reported that having a recovery coach who understands their situation builds critical trust and rapport between coach and participant. Several program participants stated that working with someone who has never been in their shoes makes it hard to open up due to fear of judgement. One AmeriCorps member remarked that although case managers go through a lot of training, recovery coaches bring their lived experience, which adds a different element.

Culturally Appropriate Services

All participating organizations try to provide culturally appropriate services to their participants. One organization (Recovery Corps) stated that they try to hire individuals who will represent the communities they will serve. Two organizations (AnB and Healing Action) reported that their services are appropriate because individuals providing direct services have lived experience. The remaining organization (FFR) stated that they have continuing education to develop culturally appropriate styles of interacting with peers (LGBTQIA+, Hispanic/Latino, etc.).

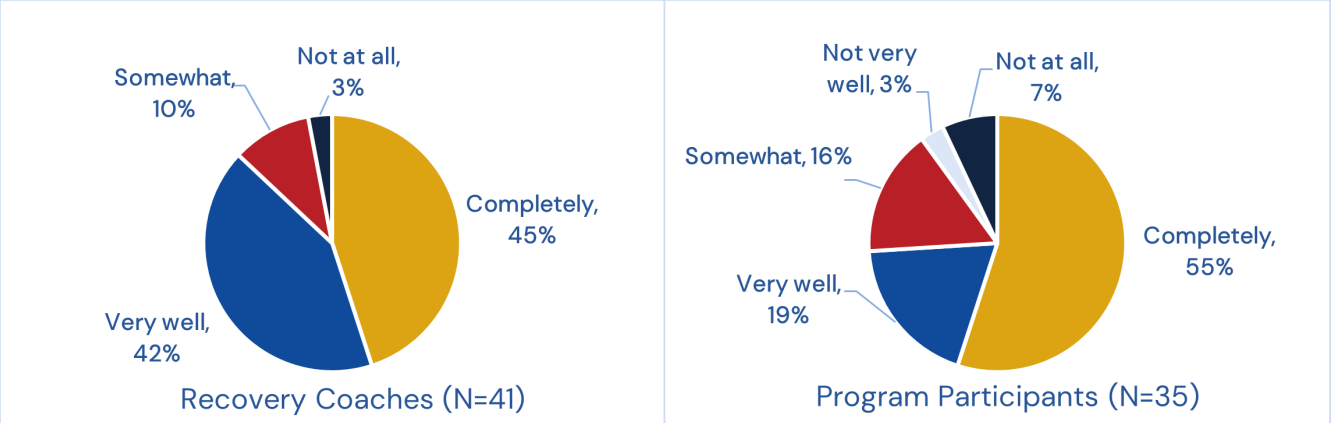
> *Many are very religious so when they have issues, they don't want to go to their priest. They want to go to the peer because the peer is less judgmental.*
>
> Recovery coach

The programs offer employees and program participants culturally responsive treatment environments. According to project director survey responses, these areas include evaluation and monitoring (all respondents), client treatment planning (80 percent), organizational values (80 percent), organizational infrastructure (80 percent), and workforce and staff development (80 percent). Only 20 percent of respondents reported culturally responsive environments for governance and none reported language service.

While 80 percent of surveyed project directors reported offering culturally responsive treatment plans, 60 percent noted that racial, ethnic, and cultural identities were assessed and incorporated into a participant's treatment plan. Only 40 percent reported including sexual orientation and gender identity or cultural approaches to healing or treatment of substance use and mental disorders. Twenty percent of directors reported the inclusion of treatment concerns related to cultural differences.

In response to the survey item that asked whether the organization's services reflect their culture and worldview, 74 percent of program participants responded "completely" or "very well." Recovery coaches had more favorable ratings with 87 percent responding "completely" or "very well" to a similar item (see exhibit 3-1).

EXHIBIT 3-1.—Perceptions of culturally appropriate treatment plans



Sources: Recovery Coach Survey, question 20: "The treatment plans I develop with my clients reflect their culture and worldviews," and Program Participant Survey, question 9: "My treatment plan reflects my culture and worldview."
Note: Sample includes 29 responses out of the 41 recovery coaches and 31 responses out of the 35 program participants who participated in the survey.

Holistic and Person-Centered Services

Holistic care is a common recovery program component across participating organizations. All participating organizations discussed their models as greater than just overcoming an SUD. The recovery models used by the organizations assist with many elements of participants' lives so they can build themselves into who they want to be using a holistic ("whole person") approach to recovery. Interviewees expressed that it is important to "care for the whole person" to maintain recovery. This holistic care entails a variety of in-house services and referrals for services such as financial, housing, and mental health support, as described in the next section. All participating organizations provide participants with personalized referrals and services. One participating organization (Healing Action) works with participants to develop personalized goals.

> *In recovery … it's not the same pathway. Every recovery story is different.*
>
> Recovery coach

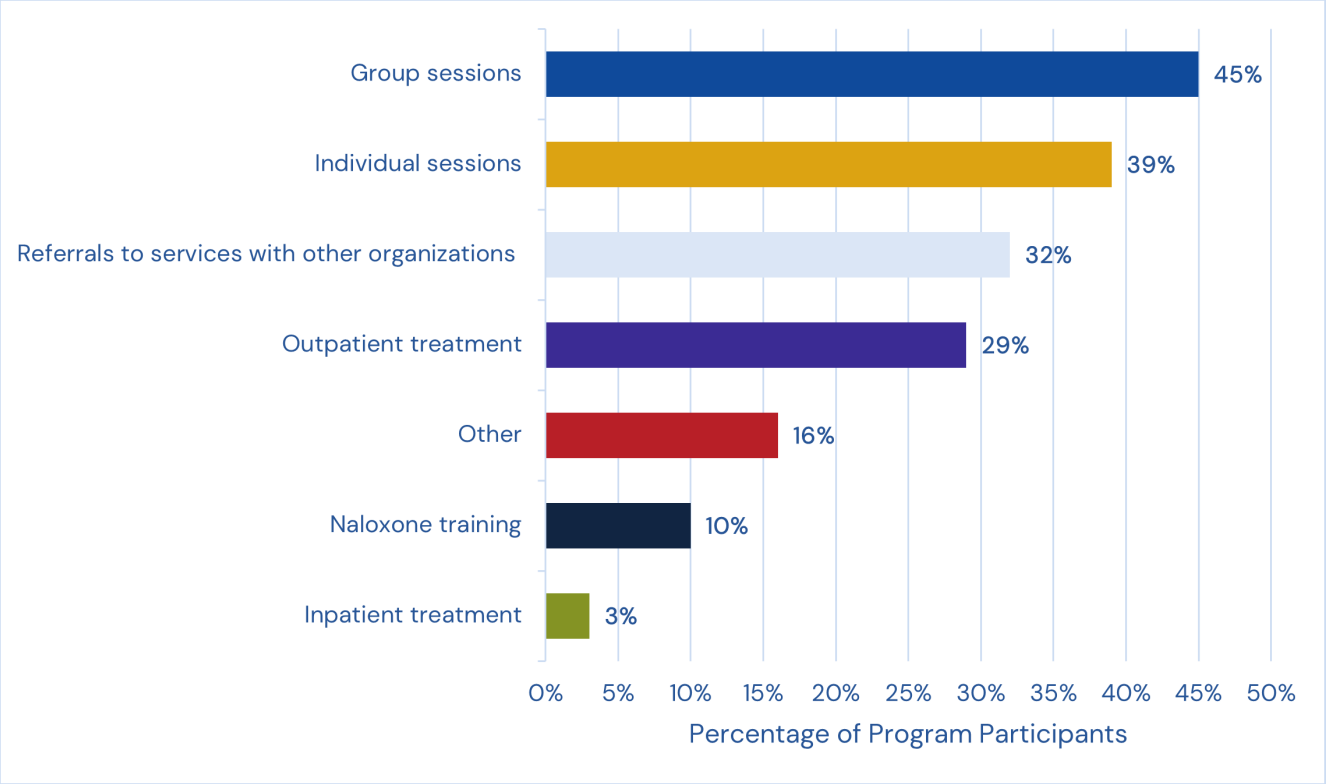
Participating organizations include harm-reduction strategies as part of the program.[5] Although only one participating organization (AnB) specifically used the term "harm reduction" to describe their in-house programming, all engage in—or have partners that in engage in—practices that fall under that umbrella. These practices include providing Narcan and needle exchanges to program participants, and "meeting them where they are" rather than shaming program participants for substance use. AnB emphasized that their services were harm reduction and Recovery Corps reported placing some AmeriCorps members with organizations that were utilizing harm reduction as well. The remaining two (FFR and Healing Action) were less clear about whether they offered harm-reduction strategies, but recovery coaches from the organizations mentioned activities such as testing opioids for fentanyl, passing out Narcan, and providing fresh needles during the interviews.

[5] SAMHSA defines harm reduction as "an approach that emphasizes engaging directly with people who use drugs to prevent overdose and infectious disease transmission, improve the physical, mental, and social well-being of those served, and offer low-threshold options for accessing substance use disorder treatment and other health care services."

Activities and Services

Program participants who completed the survey identified several services that they received, in addition to recovery coaching (exhibit 3-2). Program participants reported group sessions (45 percent) and individual sessions (39 percent), referrals to outside services (32 percent), and outpatient treatment (29 percent). Sixteen percent of respondents reported other services, including food and transportation services.

EXHIBIT 3-2.—Services received from organization by program participants (N=35)



Source: Program Participant Survey, question 2: "What type of services do you receive from your organization?"
Note: Sample includes 31 responses out of the 35 program participants who participated in the survey.

Directors, program participants, recovery coaches, and AmeriCorps members also discussed a range of services that are not directly recovery-related during the site visits. For all participating organizations, the provision of additional services is part of the holistic care model that treats the whole person in recovery. For example, Healing Action has a boutique with clothing and hygiene items as well as a section for children to pick out their own birthday gifts. The boutique's inventory is donated from the community. Exhibit 3-3 illustrates the range of in-house and referral services.[6]

EXHIBIT 3-3.—Referrals and services available to program participants

Organization	Referrals and Other Services Provided			
Above and Beyond (AnB)	• Acupuncture • Art therapy	• Employment services	• Trauma therapy	• Dance • Yoga

[6] This is not an extensive list of the services offered by each organization, but rather a compilation of services mentioned in the interviews/focus groups with the grant directors, recovery coaches, and program participants.

Organization	Referrals and Other Services Provided			
		• Housing services	• Life skills classes	
Foundation for Recovery (FFR)	• Counseling • Family support services	• Health checkups • Mail services	• Employment services • GED courses	• Clothing • Hygiene support
Healing Action Network (Healing Action)	• Transportation • Computer access	• Basic provisions • Case management	• Washroom • Relocation services	• Space to gather • Free legal services
Recovery Corps	• Social services • Health clinics	• Food • Clothing provision	• Education services • Testing (HIV, etc.)	• In-patient care • Transportation assistance

Leveraging Resources to Provide Support

Participating organizations use AmeriCorps members and VISTAs to build organizational capacity and provide services to participants. AmeriCorps members at Healing Action help with direct services to clients (i.e., answering the service line that the participants call with any requests), community education, and membership coordination. One AmeriCorps member is assisting with a 5-hour financial literacy class for program participants. Another organization (AnB) has AmeriCorps VISTAs who provide a variety of services. Services include assisting with capacity building on employment and housing, outreach to get community-based organization engagement, working with institutions of higher learning to recruit master's students to AnB for their practicum, and compliance tasks (e.g., contract requirements and documentation). AnB's AmeriCorps VISTAs also work in the food pantry and garden. AnB has a lead AmeriCorps VISTA who manages the work of the other AmeriCorps VISTAs in the organization.

Referrals to Partners for Additional Services

All participating organizations worked with other organizations and/or providers in their area to facilitate client referrals for additional services. The types of services for referral varied, but largely fell into two categories—medical services (e.g., detoxes, checkups, screenings, therapy) and supportive services (e.g., housing, financial support, meals, clothing, employment).

One participating organization (AnB) remarked that they maintain over 100 linkage agreements for services such as food, clothing, housing assistance, and furniture, but most are for medical services for individuals who relapse or are seeking detox services. Another participating organization (Recovery Corps) stated that if the program the recovery coach is working with does not provide the services a participant needs, they will connect the participant with another organization for supplemental services. Two participating organizations (AnB and FFR) spoke about the resource lists they make available to program participants. These include both local and state resources that program participants can access.

One partner (AnB) discussed how their organization provides enrichment classes for program participants. The participants engage in therapeutic music where they use music to build a "selfcare toolbox … prosocial behaviors supported by music." The partner organization also has a recovery choir that meets weekly to rehearse and performs monthly.

> *They provide all kinds of services and if they don't provide the service, they will put you in the right direction.*
>
> Program participant

Participating organizations described developing partnerships through broader statewide coalitions, coordinating with local universities and employers, conducting online research, and posting on social media. In addition, one participating organization has as part of their AmeriCorps VISTA's position description to conduct community outreach and link resources.

Other partnerships provide supplemental training for recovery coaches. Two participating organizations (Recovery Corps and FFR) include training at local colleges for topics such as suicide prevention certification. Another organization (Healing Action) received free opioid training and naloxone (an overdose reversing drug) from a local project called Missouri Opioid-Heroin Overdose Prevention and Education.

One participating organization had difficulty finding partners. Due to working specifically with adult victims of human trafficking, Healing Action relayed the difficulty of finding partnerships when people are not educated about their clients' history. According to the project director, there is stigma around human trafficking victims, and some potential partners are not inclined to help because they believe, erroneously, that trafficking is the fault of the victim.

Adapting Activities and Services During the COVID-19 Pandemic

Participating organizations had to be flexible due to the pandemic. Three participating organizations (FFR, Healing Action, and Recovery Corps) had to temporarily discontinue various in-person services. AnB's services were deemed essential, so they remained open throughout 2020 and 2021. The participating organizations took different approaches to offer in-person services while protecting against COVID-19. Measures included masking and double-masking, temperature checks, social distancing, capacity limits, hand sanitizing, face shields, increased ventilation, and socially-distanced outdoor services.

The participating organizations provided services and connected program participants with resources, even if it took longer than normal to do so. Two participating organizations (FFR and Healing Action) provide resources through services such as food drop-offs, dedicated laundry money, and basic provision deliveries with items such as personal protective equipment and socks. However, all interviewees agreed that the vulnerable populations these participating organizations serve were affected by diminished in-person services and resources, particularly at the height of the pandemic.

To make virtual services possible, participating organizations had to procure special grants to provide program participants with computers, tablets, phones, or Wi-Fi hotspots. One participating organization (Healing Action) obtained a grant to provide prepaid cell phones to participants. Technical support fell on organization staff and some did not have the capacity to always assist. While recognizing the benefits and importance of virtual services, some organizations question their efficacy, especially within the first few months of recovery. In-person services were highly preferable to almost all interviewees because recovery coaching draws its success from human connections and relationships.

All participating organizations plan to continue to provide the option of virtual services and/or use a hybrid model, but all prefer in-person services for building relationships. Multiple participating organizations have

moved overhead processes, such as training and onboarding, online, and they plan to continue to provide these virtually. Some organization staff will remain remote.

Recovery Coach Identification and Recruitment

The number of recovery coaches employed by the organizations ranged from one to forty-five. All recovery coaches were paid employees. One participating organization (FFR) reported that they have part-time and full-time recovery coaches, whereas the other participating organizations only had full-time recovery coaches. Many recovery coaches who completed the survey were employed full-time at their organization (90 percent). Most recovery coaches (76 percent) have been a volunteer at their organization for less than 1 year, with the remainder of participants (24 percent) being at the organization 1 to 5 years.

Participating organizations use multiple methods to identify and recruit potential peer recovery coaches. All participating organizations reported that they recruit peer recovery coaches from their own programs (program graduates). One participating organization (AnB) has not had to advertise for their peer recovery coach positions because they have filled all openings internally. Two participating organizations (FFR and Recovery Corps) also recruit from community recovery programs, other community organizations, and schools and universities. Two participating organizations (Healing Action and Recovery Corps) often use job sites such as Indeed to post recovery coach positions. Both also use the online platforms of recovery networks (including peer-support and trafficking survivor networks) to post positions and tap into personal connections to identify possible recovery coaches.

According to one director, it takes a special type of person to be a recovery coach. All directors identified different characteristics and skills that make for a successful recovery coach. Lived experience was the most frequently reported attribute of an effective recovery coach, followed by compassion, ability to listen and communicate, and patience. One director mentioned that the ability to set boundaries was important and another stated the ability to set and manage expectations was essential. Another director also believed that computer skills were important.

Recovery coach responses to the survey item

"I am certified by the state where I work":

- 53 percent are certified
- 30 percent are not certified
- 17 percent are working toward certification

Hiring requirements differed across participating organizations. Being a certified recovery coach was not a prerequisite to being hired for all participating organizations. The participating organizations hired individuals who were in the process of completing state requirements and would be completing their certification tests. One participating organization (AnB) pays for individuals in training to get their state certifications. They also assist individuals seeking certification to obtain a waiver for their lived experience. Another organization (Healing Action) does not require recovery coaches to be certified through the state. However, the organization's recovery coach is certified in recovery support services by the Missouri Department of Mental Health. The amount of time a coach needed to be in recovery to serve as a recovery coach also differed by organization and was sometimes mandated by state certification requirements. Recovery Corps requires 1 year of sustained recovery while others (FFR and AnB) require 2 years. Interns at FFR require only 1 year of sustained recovery. Healing Action did not provide a specific amount of time but recovery coaches "have to be sober for a while."

Challenges in Recruitment and Hiring

Participating organizations identified the criminal history background check as one barrier to hiring recovery coaches. Three project directors noted that failing the background check can be a problem when hiring recovery coaches. They said that if you want to encourage programs with lived experience, lived experience comes with backgrounds. They expect a certain level of justice involvement. One participating organization (Recovery Corps) estimated that about 95 percent of their serving members have some sort of criminal background. The organization wants to make sure that all members who can serve are able to serve and their compliance team spends a great deal of time on background checks. According to the organization, any program that has a lived experience component needs someone who can speak the language:

> *We partner with community organizations that serve the recently incarcerated populations. To be able to have a peer sit down across from someone and say, "Hey, I was there and I've been incarcerated and here are all the things that I've done to come back from that."*

Another participating organization (Healing Action) stated that the staff with the experiences they look for do not have "clean backgrounds." According to this organization, serving as an AmeriCorps member is a way for clients to get job skills because other employers are not as open to criminal offenses. AmeriCorps is open to members with some level of justice involvement if they are honest about it. However, a member can still be denied based on the background check. This is a problem when the organization likes a candidate. One participating organization (FFR) expressed dissatisfaction with the vendor that was used for the background check. The vendor did not provide transparency as to why the member could not be cleared. According to the director, "The vendor was not worth their salt."

> *Everyone is redeemable. There's going to be some that make the mistakes … but we need opportunities too.*
>
> Program participant

The background check was also mentioned by a program participant during the focus group. The participant discussed applying to be an AmeriCorps VISTA and being denied because of his background, even though 50 people wrote letters about his character. Due to situations like this, one director recommended an appeals process for the AmeriCorps background check.

Another reported barrier to hiring recovery coaches is the AmeriCorps service members' stipend. In the survey, two directors strongly disagreed with the statement "The volunteer stipend is sufficient." According to one director:

> *The volunteer stipend is a huge barrier in the recruitment process. While everyone loves the idea of service work, we need to realistically look at the current financial state of most people in the position to become members and ask ourselves if not providing a livable wage in this economy is anything but harmful.*

The stipend was also identified as a barrier by AmeriCorps members. Two members noted that you cannot live on your own and be an AmeriCorps VISTA. One recovery coach remarked that they cannot afford to stay with AmeriCorps because they need to make more money.

Certification and Training

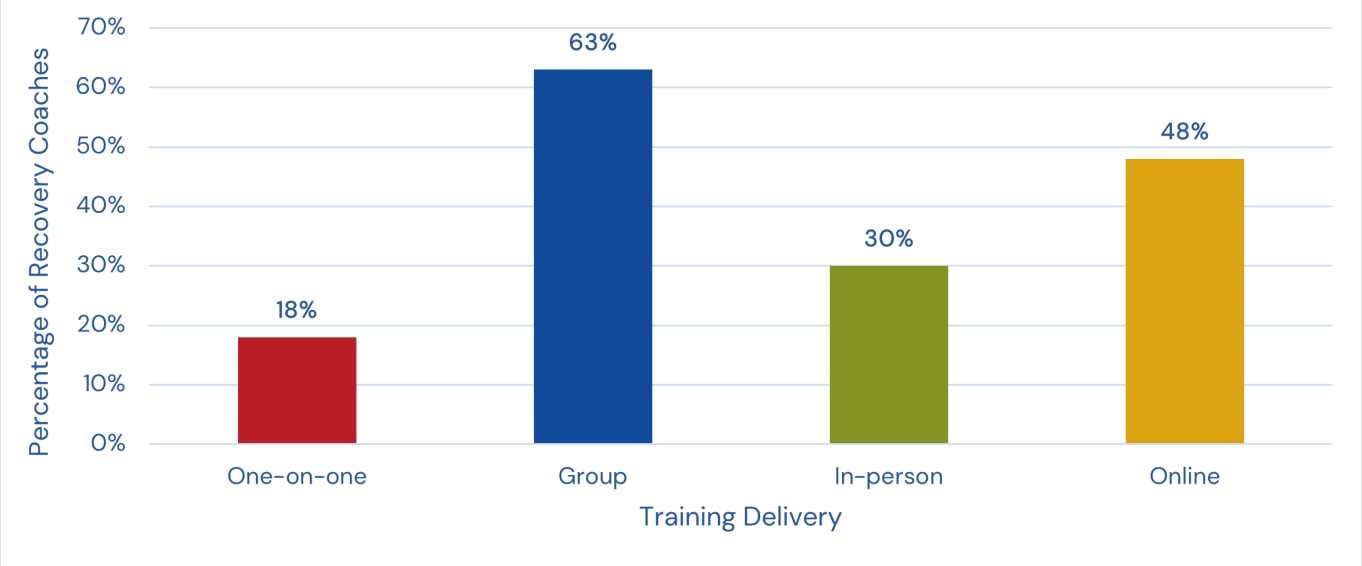
The requirements for certification as a recovery coach vary by state. Illinois has one of the most stringent requirements for recovery coaches, according to an interviewee at AnB. The certification process includes several tests and a full year of training and internships, with some exceptions for people with lived experience.

Nevada requires that peer support specialists complete 46 hours (5 days) of training and 475 hours (about 3 weeks) of service to be certified. In Minnesota, recovery coaches in training must complete 2,000 hours (about 2.5 months) of supervised work in the field to sit for the certification exam. Additional information on state certification requirements is in Appendix E.

Participating organizations also require organization-specific training for recovery coaches and other staff. All director survey respondents reported that they have an onboarding process for recovery coaches, including supervision policies and required training. Two participating organizations (Recovery Corps and FFR) require organization-specific training during onboarding in addition to the AmeriCorps training and the state recovery coach certification. One participating organization (Healing Action) provides a 3-hour organization background training and a goals meeting with the founder, followed by ongoing training that includes 4 hours of professional development per month (with optional advanced professional development being offered) and opioid and naloxone training. Another participating organization (Recovery Corps) provides their supplemental and onboarding training through a learning management system so that staff can move through the online courses at their own pace. The types of training mentioned by other interviewees include CPR and first aid, suicide prevention, life skills, proper documentation, effective communication, ethics and boundaries, work-life balance, and trauma-informed training.

Recovery coach survey respondents were asked a series of questions about the training they received. The majority of recovery coaches (90 percent) reported that they received 17 or more hours of recovery coach training. The training programs tended to use a specific curriculum or manual (66 percent), usually the state curriculum or the organization's training manual. Almost half (48 percent) of recovery coaches indicated that the training was conducted by someone outside of the organization, while 41 percent stated it was someone from the organization, and 10 percent did not know. As illustrated in exhibit 3-4, recovery coach training tended to be in a group setting (63 percent) and conducted online (48 percent). All surveyed recovery coaches found the training to be helpful.

EXHIBIT 3-4.—Modality of training for recovery coaches



Source: Recovery Coach Survey, question 8: "Was the training you received in a group or one-on-one?"
Note: Sample includes 29 responses out of the 41 recovery coaches who participated in the survey.

Program Monitoring and Tracking

All of the director survey respondents reported that they have monitoring and oversight plans. Several interviewees discussed the heavy emotional burden and potential for burnout that recovery coaches face. To combat this, two participating organizations spoke about their efforts to monitor the mental health of their coaches. One participating organization (Healing Action) has regular check-ins with their recovery coach to discuss self-care practices and vicarious trauma. They reported that this method has been successful in catching possible issues before they affect the recovery coach or their work in a significant way. Another participating organization (Recovery Corps) also implements regular check-ins but noted that with several sites and the option to work from home, it is important to include in-person check-ins because virtual ones are less conducive to understanding whether a recovery coach is struggling or not. This organization combines check-ins, office hours, and continuous communication to monitor and support recovery coaches. An interviewee noted that virtual work also presents another issue: it makes oversight difficult for approving timesheets since supervisors cannot monitor recovery coaches throughout the day.

Staff Relapses

All recovery coaches who were hired by the organizations are in recovery themselves (a critical component of lived experience). In the director survey, 75 percent of respondents reported that it was important or very important that a volunteer does not relapse to remain a recovery coach. However, only one survey respondent reported that they keep track of recovery coach relapses. In the director interviews, all participating organizations agreed that there is no "zero-tolerance policy" and that relapse would not be grounds for complete dismissal. Rather, staff relapses are dealt with on a case-by-case basis, and generally, a period of leave is given while the staff member gets back on track. One interviewee acknowledged that working with people in active addiction can be triggering for people in recovery, and that while some recovery coaches who relapse return to service, others do not. Because of this, multiple participating organizations expressed that the organization would support the staff member in whatever capacity they needed (e.g., detox, rehab, their own coach) if a relapse occurred. However, not every participating organization has had a recovery coach relapse.

One participating organization (Recovery Corps) has a relapse protocol. According to the organization, the important thing is to remove the member from the site and discuss next steps. They discuss what caused the relapse and assess whether the member has broken any AmeriCorps rules. It is a case-by-case situation, depending on the site and the member's willingness to make changes.

Program Participant Relapses and Overdoses

All director survey respondents reported that they have a process to maintain contact with clients after they enter the program. Multiple participating organizations also reported that they had participants relapse, overdose, or die during COVID-19. Organizations attribute these relapses and deaths to the stress of the pandemic on participants, a lack of support due to isolation during COVID-19, and limitations that are no fault of their own (i.e., COVID-19 restrictions requiring the closure of organizations' centers or modification of services).

Recovery Coaching

At the core of the recovery coaching programs are the individual recovery coaches. The recovery coaches provide direct support to the program participants in their recovery journey. This chapter explores the types of activities that recovery coaches engage in as well as the setting, modality, frequency, intensity, and duration of the services they provide. This also includes referrals to outside organizations. The successes and challenges are highlighted. It also presents the reported reasons for becoming a recovery coach and how the organization supports them in this role.

Peer Support

As one project director stated, "The peer model is not 'Let me do for you'—it's, 'Let me stand next to you and support you.'" During the site visits and through surveys, recovery coaches described the different types of support provided to program participants. This included emotional, informational, affiliational, instrumental, and mental health support.

Emotional Support

A key support is emotional support, where a recovery coach listens to program participants, shows concern, and provides empathy. All recovery coaches expressed that their personal experience helps them develop trust and provide emotional support. A recovery coach noted participants are more likely to open up to someone who has been through what they have been through. One recovery coach stated that she had an inferiority complex and she knows about having low self-esteem and feeling worthless. She tries to be a resource for people in similar situations because many have no one with whom to talk. In her opinion, as long as recovery coaches have authenticity and empathy and make connections with program participants, the participants will continue to make positive changes.

> *I said I just want to talk for a minute. And so, they let me talk. They cried with me and they let me get this mess out.*
>
> Program participant

One recovery coach stated that the way she helps is by listening to the program participants and talking through things with them. She stated that in active addiction everyone tells you what you are doing wrong and what you should be doing. She helps them feel heard and lets them know that every addiction is different. She helps them find their own path to recovery. Another recovery coach remarked that she also gives the participants the opportunity to talk, share their feelings, and have open discussion. The recovery coach stated that no matter how bad things get, there is "always a light at the end of the tunnel." This is what she tries to give to others.

The program participants contact the recovery coaches when they have the urge to use and the recovery coaches need to be ready to help them. One recovery coach stated that some of her participants have opioid prescriptions to manage pain. She does not tell them what to do because she does not want to appear confrontational. Rather, she listens to the participants' concerns and discusses the different pathways to manage pain.

recovery coaches are also called upon to provide emotional support when participants are working with their case managers. One example was shared by an AmeriCorps member. A case manager was having a routine meeting with a participant and the participant was very troubled by a family member who was having issues with an SUD. The case manager called in the recovery coach to have a conversation with the participant. The recovery coach discussed how her relationships were affected by SUDs, and how she had to put boundaries in place. The conversation about establishing boundaries was helpful to the participant.

Informational Support

All recovery coaches discussed providing informational support to the program participants. This includes connecting participants to community resources as well as sharing knowledge and information. One recovery coach stated that her typical day consists of online research, finding resources in the area for program participants (e.g., treatment or detox centers). She also helps with the justice-involved program—being a pen-pal for persons who are incarcerated to help connect them with recovery resources before they transition out of prison.

> *I will definitely give them names of facilities that I have experience with or I've heard good things about and then [the participants] make the phone call.*
>
> Recovery coach

Another recovery coach discussed assisting program participants in their job search by developing resumes and helping them navigate job search websites. He stressed the importance of networking and having connections in the community:

> *Doing things so you have those connections everywhere. It's not just referring your clients to Indeed.com and saying, "Here's how you do a job search." But saying, "This is a gentleman in the city who hires people that are in recovery to do construction work. Call him. Tell him that I sent you." You know those things help out.*

Affiliational Support

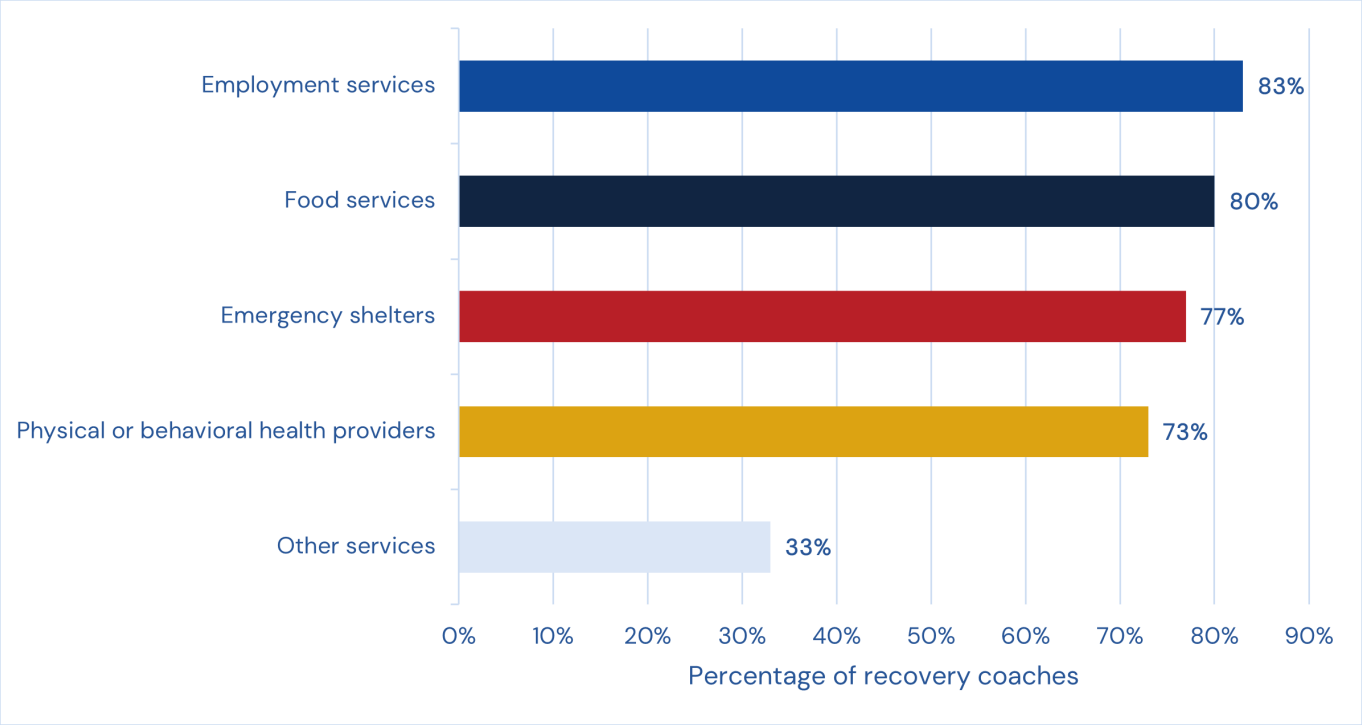
All recovery coaches provide connections to recovery community supports, activities, and services (known as affiliational support). Common affiliational supports include resources about Narcotics Anonymous (NA) or Alcoholics Anonymous (AA). There are also recovery-friendly social activities and events provided by the organizations or the communities. One recovery coach creates a newsletter for program participants, informing them about different recovery community events, including music in the park, food/potluck dinners, and water day at the park. The newsletter also includes kudos for participant accomplishments (e.g., graduation, getting into the rent assistance program).

> *One important thing is that they provide leisure time—a quiet place to just be—and entertainment like group parties.*
>
> Program participant

Instrumental Support

All recovery coaches reported that they provide instrumental support—concrete assistance to accomplish a task—including referrals to outside services. As seen in exhibit 4-1, the referrals to outside services include employment services (83 percent), food services (80 percent), emergency shelters (77 percent), and physical or behavioral health providers (73 percent). Other service referrals included education services, housing services, and legal services.

EXHIBIT 4-1.—Referrals to outside services provided by recovery coaches (N=41)



Source: Recovery Coach Survey, question 19: "What other supports do you connect clients to?"
Note: Sample includes 30 responses out of the 41 recovery coaches who participated in the survey.

In the interviews, all but one recovery coach discussed the different service referrals that they provide to program participants and how they help the participants navigate outside services.[7] One recovery coach provides referrals for housing, including emergency shelters, sober homes, and long-term housing. The recovery coach has a "shelf full of resources" on housing and food pantries depending on where the participants are in the city. Other recovery coaches discussed referrals for counseling services, legal services, and employment.

The recovery coaches also provide tangible services. For example, a recovery coach was assisting a program participant who was incarcerated. She reached out to their probation officer, sent documents, and set up a home plan so that the person could get early release. The recovery coach also would drop off basic needs at participants' homes. Another recovery coach talked about her time as a program participant at the organization and how they helped furnish her apartment.

> *[Recovery coaches] are working in conjunction with the counselors to say, "Hey, here are the things that I'm helping this member with, we're looking at housing for afterwards or a job for after or getting a license back." So they're really kind of working on some of those supports they need in order to transition back into the community upon discharge.*
>
> Project director

[7] One recovery coach stated that they do not do a lot of referrals because their participants "do not need it."

One recovery coach believes that it is part of his role to advocate for the program participants to get concrete supports. For example, recovery coaches cannot contact insurance for transportation needs (e.g., bus passes) but case managers can. The recovery coach will sit with the program participant while they contact the case manager. If the participant is apprehensive, he will reach out to the case manager on their behalf.

Mental Health Support

The four programs served individuals with SUDs and mental health diagnoses. Consequently, recovery coaches also provided mental health support for individuals with post-traumatic stress disorder (PTSD), depression, or anxiety. One participating organization (Healing Action) helps program participants get back into the community since they have a lot of anxiety after commercial sexual exploitation. The recovery coach, in collaboration with the AmeriCorps members, helps to address the mental health needs of the program participants who are victims of trauma. Other participating organizations (AnB and FFR) have groups specifically designed to help participants overcome trauma. FFR has a veterans trauma group (called Battling Shadows) that uses a cognitive-behavioral approach to treat trauma.

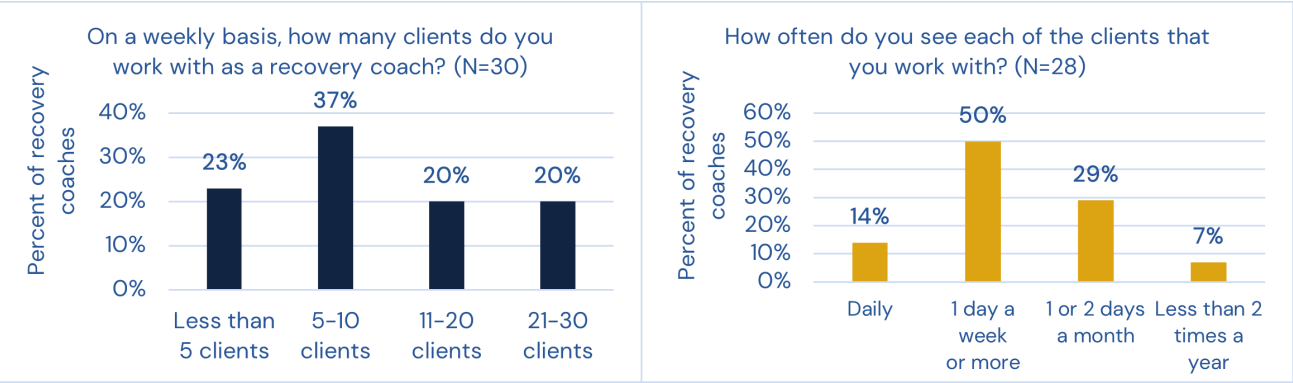
> *Every recovery story is different. Some [clients] want therapy, some prefer peer support. [The recovery coach] puts labels on bricks and creates a "foundation" for recovery.*
>
> Recovery coach

One recovery coach experienced trauma (physical and sexual abuse) in the past and is matched with participants who can relate to her experiences. She stated that she feels a part of the women's trauma and sobriety groups because she has "true empathy" for those participants. Another recovery coach stated that she works primarily on the mental health supports as she has obsessive-compulsive disorder, anxiety, and major depression.

Caseload, Duration, and Intensity of Services

Surveyed recovery coaches were asked about the number of program participants that they worked with each week and how often they see the participants (exhibit 4-2). Larger percentages of recovery coaches reported that they worked with 5–10 participants per week (37 percent), with 23 percent working with less than five, and 20 percent working with more than 20. Half of recovery coaches reported that they see each participant at least once a week, while 29 percent reported seeing each participant 1 to 2 days per month. Only 14 percent of survey respondents reported seeing each participant daily.

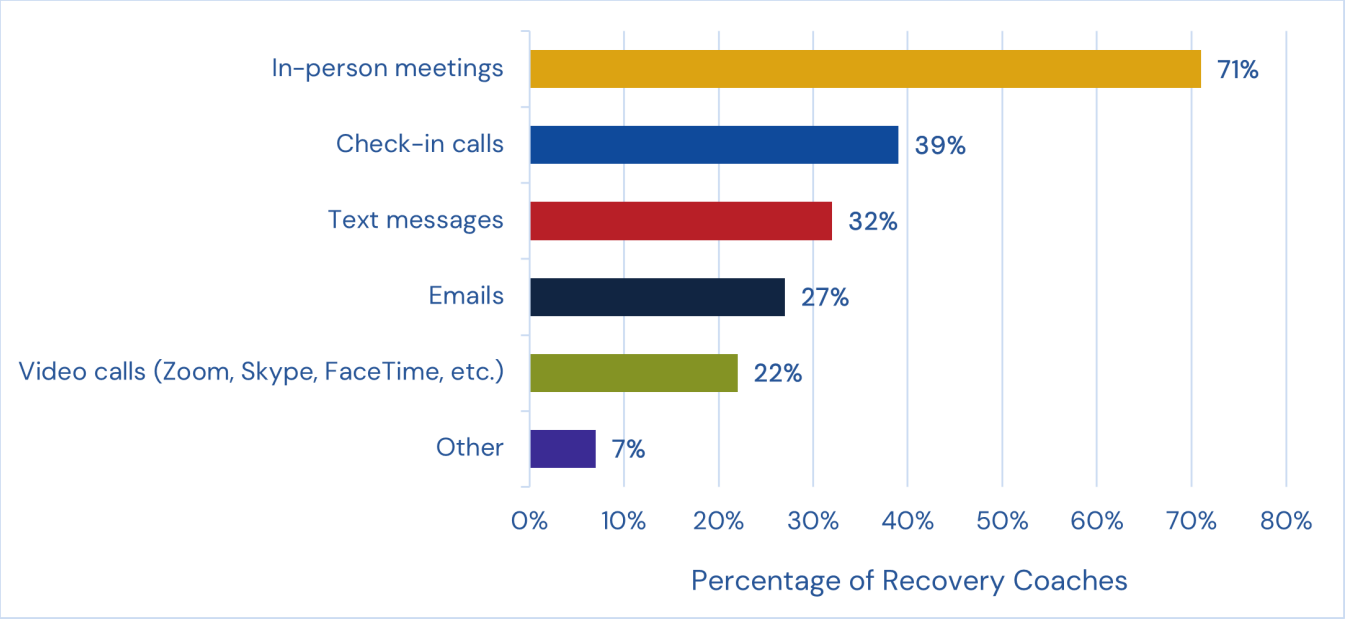
EXHIBIT 4-2.—Number of participants and frequency of sessions



Source: Recovery Coach Survey

Almost half of recovery coaches (45 percent) worked with the same participants each week, while 17 percent reported that the organization rotates participants among recovery coaches. On average, most recovery coaches spent 1 to 4 hours with each participant per week (60 percent). However, 30 percent of recovery coaches reported that they spent less than 1 hour with each participant per week. As seen in exhibit 4-3, the majority of recovery coaches had in-person meetings with their participants (71 percent) and 22 percent of recovery coaches met virtually via video. Other modes of contact included check-in calls (39 percent), text messages (32 percent), or email (27 percent). According to the survey respondents, larger percentages of recovery coaches provide individual sessions or case management (77 percent) than group sessions (33 percent).

EXHIBIT 4-3.—Mode of interaction between recovery coaches and program participants



Source: Recovery Coach Survey, question 17: "What mode of interactions do you have with clients?"
Note: Sample includes 30 responses out of the 41 recovery coaches who participated in the survey.

During the site visits, recovery coaches were asked how many program participants they worked with per day and their caseload. They were also asked about the setting, modality, frequency, intensity, and duration of the services they provided. The caseload and intensity of services varied based on where the recovery coach worked.

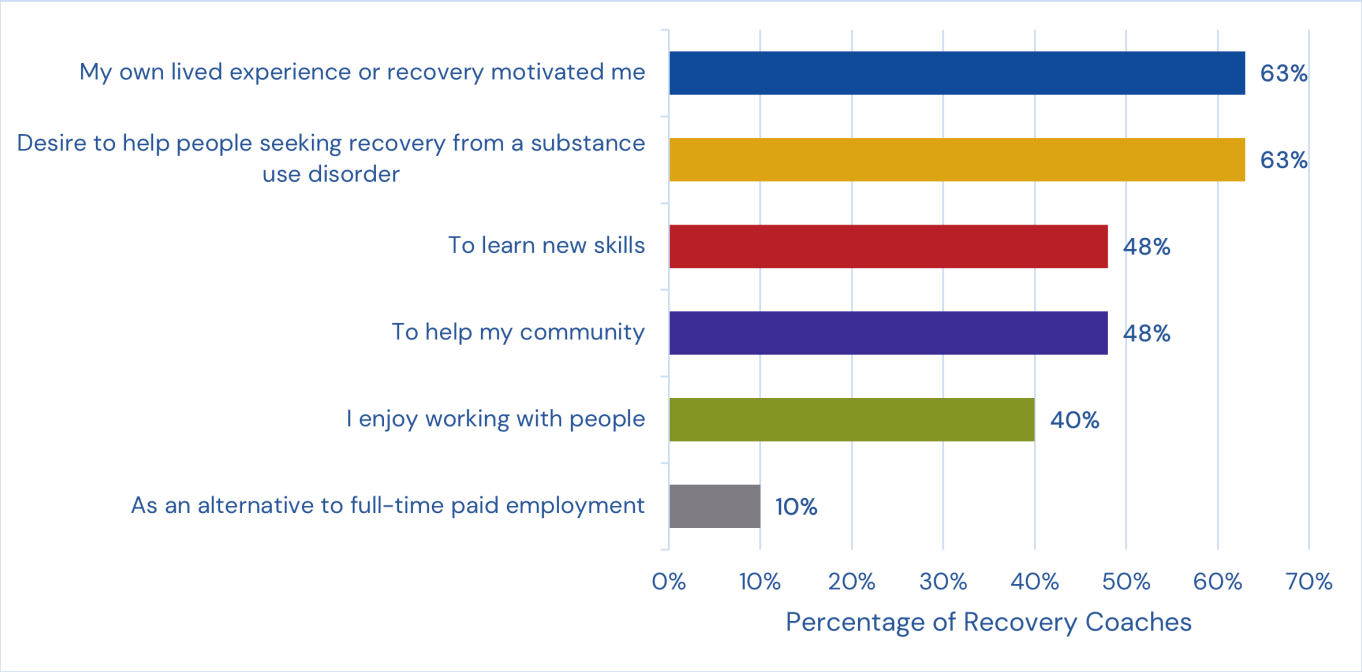
- One recovery coach is the only one in her region and she covers many counties. Her full caseload is 30 participants. Of these, 10 are fully in recovery. She does brief check-in appointments with the individuals who do not want to be in the system officially (20 participants).
- Another recovery coach stated that she works with about 30 participants per week. Most of her work is one-on-one and she does phone and Zoom chats. She meets with participants either daily, weekly, or every other week.
- One recovery coach provides both individual and group sessions. She works with 10–20 people per group/class. The classes can have up to 40 participants. She has completed five one-on-one sessions. She sees the same general group of people but different people come in every day.

- One recovery coach stated that there are 15 participants getting resources and doing therapy, and she sees them throughout the week. She also invites them to groups and events. She checks emails, returns calls, checks with case managers for participant needs, and drops off basic needs at participant homes. She connects with participants with needs and in crisis on the service line. According to this recovery coach, "Every day is a different day—there's a lot of change and challenge."
- Another recovery coach works in an outpatient center and there can be up to 300 people coming through the center every day (they have many walk-ins). He is in a clientele-building role. At any given time, he has a caseload of between 20 and 30 participants. He stated that he works with three participants per day in individual, face-to-face 30-minute to hour-long sessions. He also conducts check-in phone calls with 20–30 participants to make sure they are coming in. Participants cannot miss more than 3 days of dosing or they must be reinstated to continue with the program.

Reasons for Becoming a Recovery Coach

The recovery coaches who responded to the survey were asked why they chose to become a recovery coach (exhibit 4-4). The most frequently reported reasons for becoming a recovery coach included their own lived experience or recovery (63 percent) and the desire to help others seeking treatment from an SUD (63 percent). Smaller percentages of recovery coaches reported that they became recovery coaches to help their community (48 percent), learn new skills (48 percent), or because they enjoy working with people (40 percent).

EXHIBIT 4-4.—Reasons reported for becoming a recovery coach



Source: Recovery Coach Survey, question 4: "Why did you choose to become a recovery coach?"
Note: Sample includes 40 responses out of the 41 recovery coaches who participated in the survey.

During the interviews, one recovery coach stated that she was a participant originally. The organization made her feel cared for, loved, and supported. They helped her get back on her feet. The therapists and case

managers were "great" but the support was priceless because of the connection to the coaches. Now, being a coach supports her recovery because she models what change and hope can look like.

> *It's also a good refresher … these people that I work with every day, that's where I was not long ago.*
>
> Recovery coach

One recovery coach stated that he was drawn to recovery coaching because of his own experiences in recovery. He did not have a recovery coach but found that the folks who could relate to him the most made the biggest difference. He said, "We need support." Another recovery coach who did not receive support in her recovery expressed that she wanted to be in this field but did not know how. She is grateful for her organization because they helped her navigate the process.

Challenges and Solutions

Recovery coaches work with individuals with an SUD. A harsh reality of this work is that program participants may overdose while in treatment. This can be devastating for recovery coaches and presents unique challenges for a coach to navigate as they attempt to maintain sobriety while helping others achieve sobriety themselves. One recovery coach shared that her organization has a ceiling covered with doves with the names of people who have died of an overdose. She tells visitors about it because it is powerful for her and others.

Two recovery coaches discussed the requirement of the 1-year minimum of sustained recovery to become a recovery coach as a challenge. Both expressed concern that the time was not sufficient. In one coach's opinion, "You're not in recovery in the first year, you're basically an addict who's trying not to use." She described the role of a recovery coach as "stressful," "high-pressure," and "triggering to hear their stories." The other recovery coach noted that many people struggle in their job and relapse.

Many program participants have mental health diagnoses and are dealing with trauma. One recovery coach has a traumatic past and she works with others going through similar situations. She expressed that her role is challenging because it can be emotionally intense; sometimes she needs to remove herself from the session and take a moment to compose herself. Another recovery coach with a traumatic past stressed the importance of self-care and meditation. She stated that a challenge is getting the individuals who need the services to come.

> *Sometimes it's very hard to accept that you cannot help someone. You have to realize that you're there to help, but you can't save everyone.*
>
> AmeriCorps member

Several recovery coaches mentioned that people have to want the help and you "cannot force people to get clean." They also acknowledged that you cannot help everyone. One recovery coach mentioned that at his location, people come in for dosing and leave. The population they serve is in early recovery. There is no requirement for group meetings so the difficulty is keeping people motivated and on-task. He said that it is on the individual to have the motivation to recover.

For one recovery coach, the biggest barrier was when a person's needs were not met. She elaborated that the person would not open up. She knew that something else was going on but could not pry and that made it hard to help them. She stated that she feels hopeful when she sees them again and knows they are still alive.

Another recovery coach discussed the difficulty of trying to implement harm-reduction strategies in her area. The people in the area have misconceptions about the strategies. For example, they perceive that putting out fresh needles or putting out condoms is enabling people. She mentioned that there were outbreaks of

hepatitis and HIV and she was trying to keep people healthy and save lives. However, she was unable to change their misconceptions.

One recovery coach stated that the biggest barrier to being a recovery coach was that he did not have the same cultural background as the individuals being served at his site. The recovery coach described himself as a "pansexual gender nonconforming White dude" working with "older Black gentlemen." He stated that he can relate to them on many recovery-related issues but cannot relate to how they grew up. He does whatever he can to understand but some participants do not think he can help because of this cultural difference.

For one recovery coach, the biggest challenge was continuing to work on herself. She has been sober for 3 years but says it is not a long time. Although she has come very far, she believes she still has work to do. She has days when she is depressed and days when she misses using but "she has to get up and be there for people."

Support for Recovery Coaches

As discussed in Chapter 3, all participating organizations have monitoring and oversight plans for recovery coaches. This includes monitoring their mental health. In the project director survey, all participating organizations reported that the organization provides opportunities for recovery coaches to connect with each other. This provides a means of support for the recovery coaches.

All recovery coaches reported that they have support from other coaches to do their job. One recovery coach mentioned that there is another recovery coach at the center and he was "an absolute blessing to have" due to his lived experience (30 years of sustained recovery). The recovery coaches also have support from leadership at their organization. One recovery coach discussed the support from his supervisor, who helped in the first few months when he was overwhelmed with the work. Another recovery coach stated that the recovery coaches and leadership are in constant contact, which she finds helpful.

One recovery coach remarked that she would love to have her peers near her because "it gets kind of lonely; when bad things happen, it feels even more so." She discussed how some individuals cannot handle the job when they are on their own because it can be overwhelming. However, she praised the organization's leadership for being there for her.

Program Outcomes

As shown in Chapter 2, outcome indicators based on survey and interview/focus group protocols assessed whether participating organizations, recovery coaches, and program participants were able to achieve their intended results based on the program activities. In this chapter, analyses of the capacity building outcomes for participating organizations are presented. The perceived influence on recovery coaches' ability to work with program participants—while maintaining their own recovery—is also discussed. In addition, for program participants, this study addressed whether they were able to achieve improvements in recovery capital, uptake of services, and reduction in use of substances. While analyses approaches and small sample sizes limit the ability of the study to yield generalizable findings, a comparison of participants' outcomes to outcomes of others in treatment who did not use a coach as a part of their recovery process (i.e., a comparison group) allows for outcome evaluations based on participation in recovery coaching.

Participating Organization Outcomes

The main outcomes for participating organizations included organizational capacity to provide services, ability to leverage grant financial support, and collaboration with partners and community resources.

Organizational Capacity

In the project director/manager survey, directors were asked to rate their level of agreement (on a scale of strongly agree to strongly disagree) with a statement about organizational capacity. All project directors agreed or strongly agreed that their program has the organizational capacity to provide services. The interviews with project directors corroborated the survey results. One participating organization (Healing Action) reported that their clients are getting more services because there are more people (AmeriCorps members) available to see them. The director also noted that the volunteers often bring in new experiences and ideas that benefit their program. For example, the volunteers expand the organization's capacity into rural areas. The coalition coordinators are usually from a rural area and break down the barriers of communication they have experienced with rural communities. Similarly, another participating organization (AnB) credits AmeriCorps member support for expanding their visibility in the community. In addition to helping with reporting, project management, and capacity building, they also coordinate with local institutions of higher education to recruit interns to AnB for their practicum (approximately 70 master's students who are working on their counseling practicum). One participating organization (Recovery Corps) provides recovery coaching in Minnesota and Illinois and is expanding to California and Virginia due to support from AmeriCorps.

Ability to Leverage Grant Financial Support

All project directors agreed or strongly agreed that their program can leverage grant financial support. One participating organization (Healing Action) won a 3-year, $1.2 million grant from a national foundation in 2015 that allowed them to get an office and staff. As of June 2022, the organization served over 300 individuals and has 15 full-time staff and 30 AmeriCorps staff (AmeriCorps State and National members and AmeriCorps VISTAs). Their operating budget grew from about $350,000 per year to $1.3 million per year. In addition to AmeriCorps funding, Healing Action receives funds through Saint Louis (Mo.) Mental Health Board, Missouri Housing Trust Fund, the U.S. Department of Justice's Office for Victims of Crime, and other smaller grants (e.g., a COVID-19 relief grant to provide food and a technology grant to provide phones for program participants to access virtual services).

One participating organization (AnB) recently applied for a harm reduction grant with Smart Recovery in Ohio. Smart Recovery and AnB plan to expand harm reduction and substance use alternative programming to rural communities.

Another participating organization (FFR) reported that they would not have a program if it were not for support from AmeriCorps. The organization received a planning grant from AmeriCorps and supplemented it with private funding. The last participating organization (Recovery Corps) supplemented their AmeriCorps funding with public and private funding. However, none of the participating organizations received a federal opioid development grant.

Collaboration with Partners and Community Resources

All project directors reported high levels of agreement with the statement, "My program is able to collaborate with partners, organizations, and community resources." As discussed in Chapter 2, the participating organizations worked with different organizations to provide medical services and supportive services. As the program models are holistic, they have partners to assist in providing financial, housing, and mental health support.

One participating organization (AnB) has over 100 linkage agreements with organizations around Chicago, Ill. These organizations provide health and behavioral services, food, clothing, housing assistance, and furniture. AnB is now partnering with the Supportive Housing Providers Association, a statewide association of nonprofit supportive housing providers in Illinois. This organization is a grant-making organization through the Illinois Department of Human Services. The Supportive Housing Providers Association provides technical assistance to emergency and transitional housing and supportive housing organizations, with a goal of providing training and technical assistance services to these organizations to expand their harm-reduction programming for their SUD services. The director also stated that most of AnB's partner organizations refer participants to them for services.

Another participating organization (Healing Action) now houses a statewide coalition against trafficking and exploitation, and it has made them a connection point for anyone doing any anti-trafficking work in Missouri. This helps program participants who need to leave the city since there are trusted partners in other cities and towns to help them. Healing Action has partnerships with landlords of complexes with multiple properties where they can move the participant to another location without difficulty. They educate the landlords on what they might see, how they need to act, and how to communicate with the organization if a participant is in danger (i.e., when traffickers try to track down survivors). The organization also helps other nongovernmental agencies access resources, especially those in rural areas. They have connections with churches in rural areas that house trafficking victims and they can help train them to scale up the church's services.

Like the other participating organizations, Recovery Corps partners with several organizations. They partner with in-patient programs that can provide partial hospitalization programs if someone overdoses as well as social services organizations that provide detox services. Their partners provide community education programs, help with computer skills, naloxone training and handouts, meals, and clothing, among other services. The project director remarked that if a program the member uses does not provide the services a participant needs, they will connect the participant with another organization for these services. Similarly, FFR has 121 trusted referral partners, including counseling services and workforce partners. Roseman University's College of Medicine physician's assistant program provides checkups for the participants.

Recovery Coach Outcomes

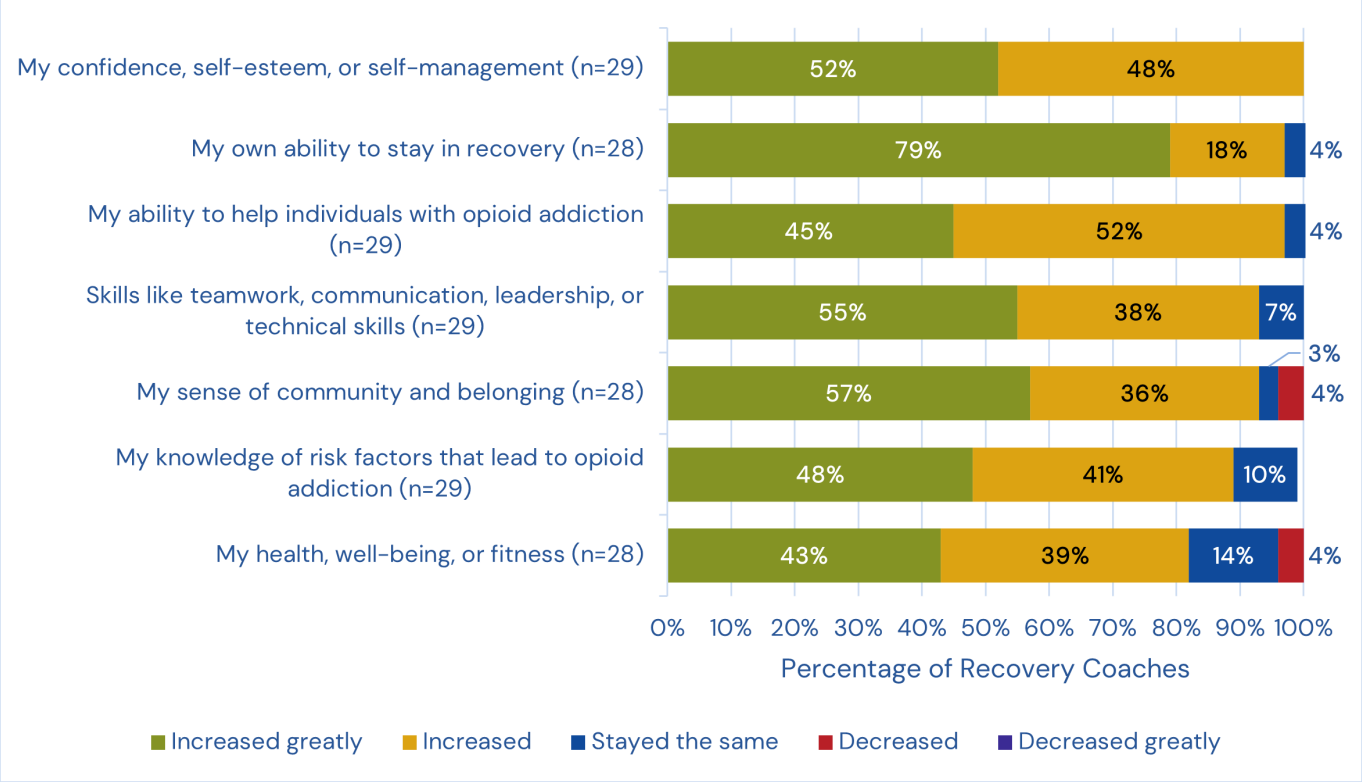
The main outcomes for recovery coaches included increased knowledge, improved attitudes, and improved behaviors as well as increased opportunity of maintaining their own recovery.

Perceived Changes in Knowledge, Attitudes, and Behaviors

recovery coaches rated their changes in knowledge, attitudes, and behaviors since becoming a coach (exhibit 5-1) on a 5-point scale (i.e., "increased greatly," "increased," "stayed the same," "decreased," or "decreased greatly"). Overall, the majority of recovery coaches reported increased (i.e., increased or greatly increased) knowledge, attitudes, and behaviors since becoming a coach:

- 100 percent reported increased confidence, self-esteem, or self-management;
- 97 percent reported increases in their own ability to stay in recovery,
- 97 percent reported increases in their ability to help individuals with opioid addiction;
- 93 percent reported increased skills like teamwork, communication, leadership, or technical skills;
- 93 percent reported an increased sense of community and belonging;
- 89 percent reported increased knowledge of risk factors that lead to opioid addiction; and
- 82 percent reported increased health, well-being, or fitness.

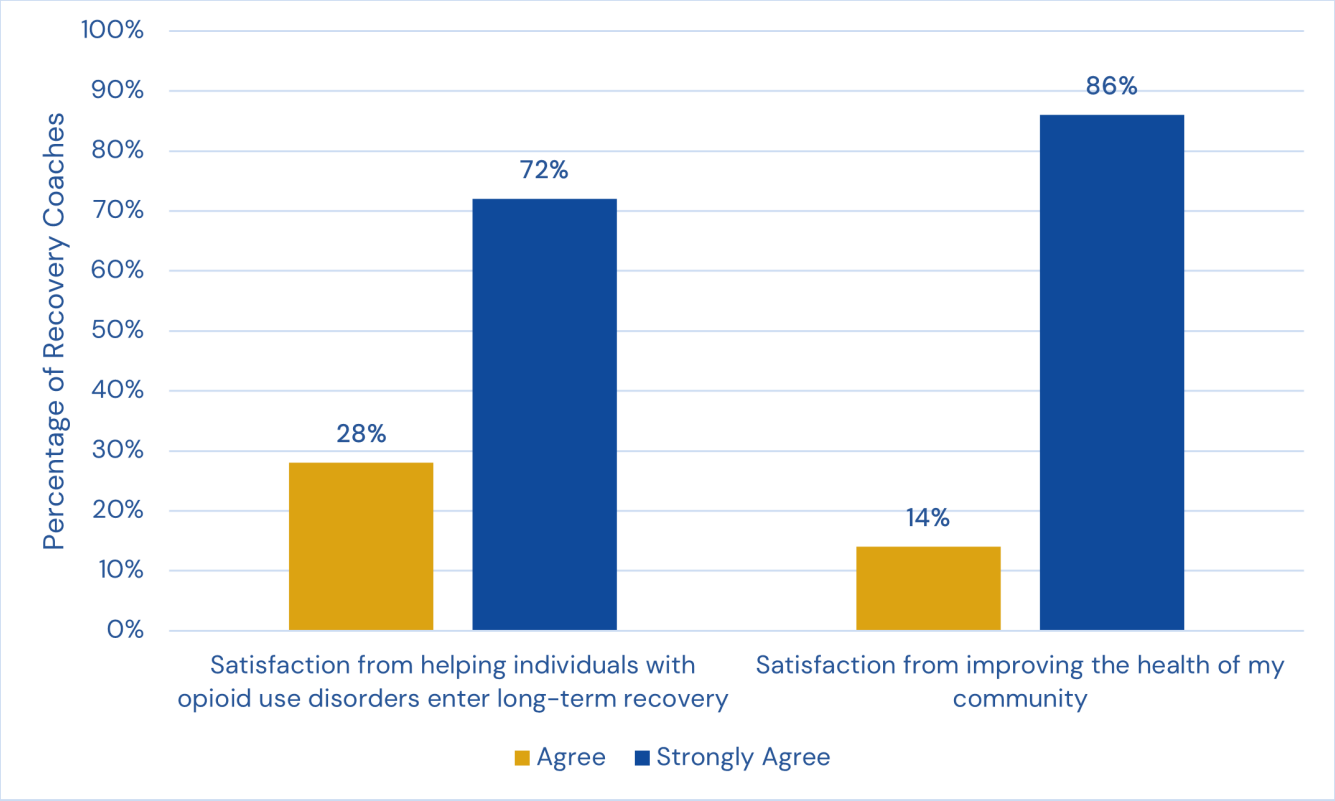
EXHIBIT 5-1.—Recovery coach self-reported changes in knowledge, attitudes, and behaviors



Source: Recovery Coach Survey, question 24: "Please rate the following statements based on whether each factor has increased or decreased for you since becoming a recovery coach."
Note: Totals may not add up to 100 due to rounding. Not all survey respondents responded to each item in the survey, which accounts for an inconsistent number of responses to different items in the survey.

In an interview, one recovery coach discussed how recovery played a critical role, not just in getting clean, but in staying clean. Now, being a coach supports her recovery because she serves as a role model to others. Another recovery coach noted that being a recovery coach helps him stay in recovery and gives him a sense of purpose. Exhibit 5-2 presents the benefits of being a recovery coach as reported by survey respondents. Overall, recovery coaches received satisfaction from improving the health of their community (86 percent strongly agreed) and helping people with opioid use disorders enter long-term recovery (72 percent strongly agreed).

EXHIBIT 5-2.—Self-reported benefits of being a recovery coach



Source: Recovery Coach Survey, question 22: "How much do you agree or disagree that you get these benefits out of being a recovery coach?"
Note: Sample includes 29 responses out of the 41 recovery coaches who participated in the survey.

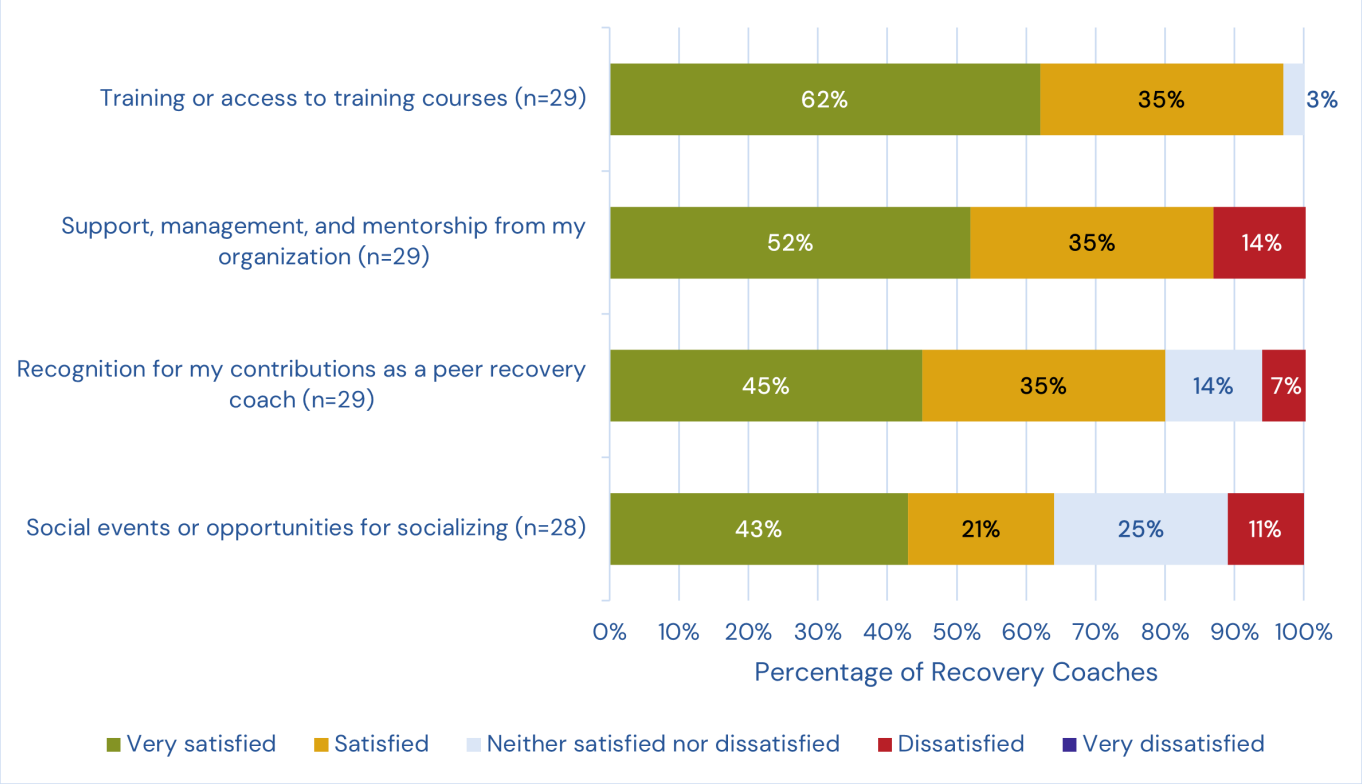
During the interviews, recovery coaches were asked how their own recovery or lived experience affected their work. One recovery coach responded that being a coach has helped her. She never clicked with AA or NA and was told that if she did not do AA, she would not recover. She considers this job as her own AA because it helps her reflect. She does not want to give advice on things she does not do herself. It keeps her accountable in her own recovery.

Another recovery coach praised the coaching model and believed his lived experience helps him in his work. While his addiction was to alcohol and he does not have much experience with opioids, people open up to him faster than others because of his background.

In the survey, recovery coaches were asked to rate their satisfaction with different aspects of being a recovery coach (exhibit 5-3). The majority of participants (97 percent) were satisfied or very satisfied with

the training or access to training courses. Larger percentages were satisfied or very satisfied with organizational support (87 percent) and recognition for their contributions (80 percent). However, only 64 percent of recovery coaches were satisfied or very satisfied with socialization opportunities or events.

EXHIBIT 5-3.—Self-reported satisfaction with being a recovery coach



Source: Recovery Coach Survey, question 23: "How satisfied are you with the following aspects of being a recovery coach?"
Note: Totals may not add up to 100 due to rounding.

Program Participant Outcomes

The main outcomes for program participants included increased recovery capital, increased attendance to more physical and behavioral health services, and decreased incidence of substance use.

Recovery Capital

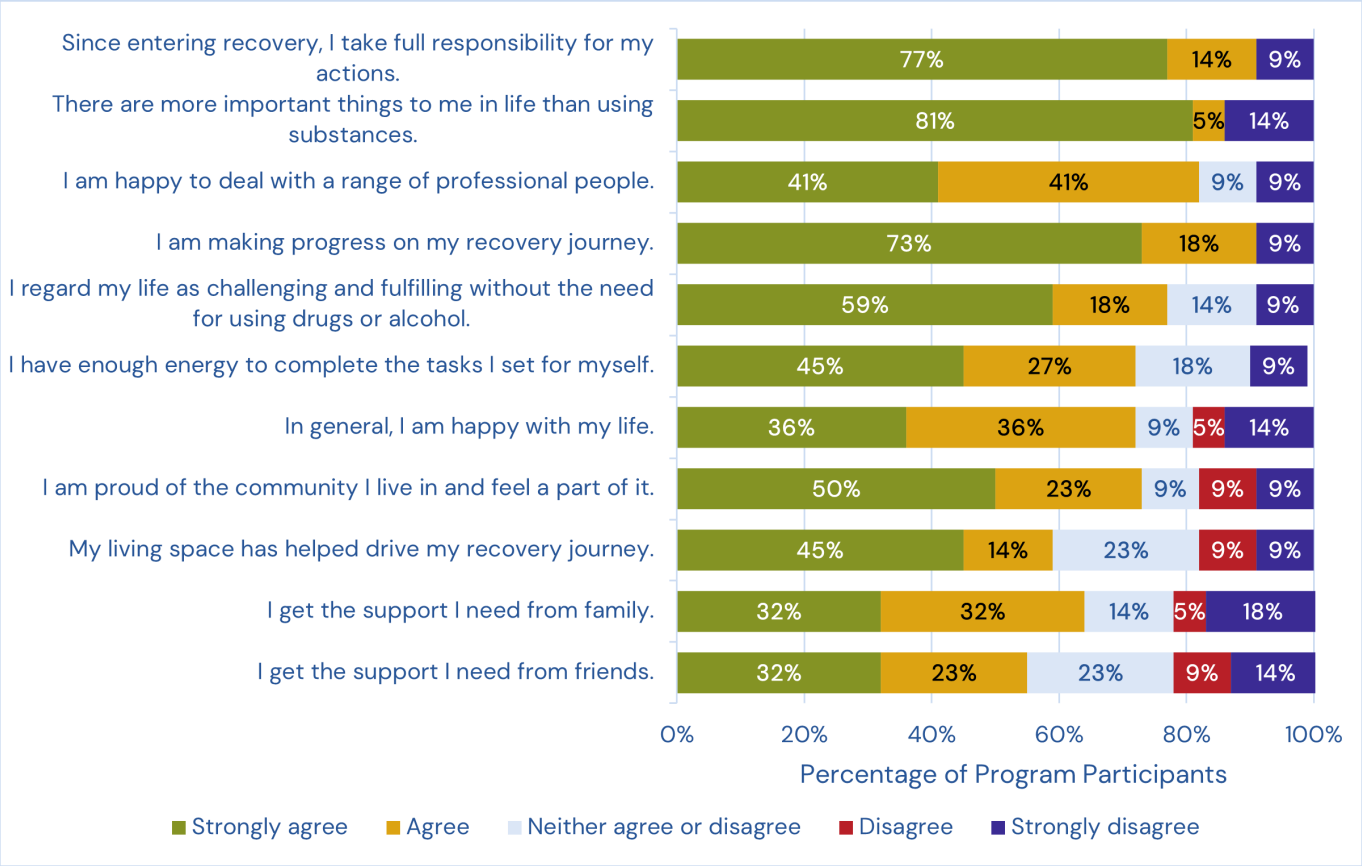
Recovery capital comprises an individual's internal and external resources that help to enhance capacity for and commitment to living a sober life. There are three types of recovery capital:

- **Family/Social** – Resources related to intimate relationships with friends and family, relationships with people in recovery, and supportive partners; also includes the availability of recovery-related social events.
- **Personal** – Includes an individual's physical and human capital.
  - Physical capital contains the available resources to fulfil a person's basic needs, such as their health, healthcare, financial resources, clothing, food, safe and habitable shelter, and transportation.
  - Human capital relates to a person's abilities, skills, and knowledge, such as problem-solving, education and credentials, self-esteem, the ability to navigate challenging situations and achieve goals, interpersonal skills, and a sense of meaning and purpose in life.

- **Community/Cultural** – Community capital includes attitudes, policies, and resources specifically related to helping individuals resolve SUDs. Cultural capital includes resources that resonate with individuals' cultural and faith-based beliefs.

Survey items, adapted from the Brief Assessment of Recovery Capital (BARC-10; Vilsaint et al., 2017), measured the program participants' self-reported recovery capital on a 5-point scale ranging from strongly disagree to strongly agree. As illustrated in exhibit 5-4, program participants reported levels of agreement of 50 percent or higher for all items. The highest levels of reported recovery capital among program participants were with the items "Since entering recovery, I take full responsibility for my actions" (91 percent); "There are more important things to me in life than using substances" (86 percent); "I am happy to deal with a range of professional people" (82 percent); and "I am making progress on my recovery journey" (91 percent). The lowest agreement was the item "I get the support I need from friends" (55 percent).

EXHIBIT 5-4.—Program participant responses to recovery capital survey items



Source: Program Participant Survey
Note: Sample includes 22 responses out of the 35 program participants who participated in the survey.
Totals may not add up to 100 due to rounding.

To understand what would happen in the absence of recovery coaching, the recovery capital outcomes of program participants were compared to comparison group members (exhibit 5-5). Mean scores for each recovery capital survey item indicate that program participants had higher agreement with all 11 recovery capital items, generally indicating greater recovery capital among program participants. Statistical testing used Mann-Whitney U tests to compare two independent groups (participant and comparison) with non-

normal distributions of response data. Results showed marginal statistical significance (defined as p-value < 0.10) in between-group difference for three items ("I am proud of the community I live in and feel a part of it"; "Since entering recovery, I take full responsibility for my actions"; and "I am making progress on my recovery journey"). The small sample sizes warrant caution in interpreting these findings, and a deeper dive with more participants may be helpful to confirm the findings of the potential recovery capital benefits of recovery coaching.

EXHIBIT 5-5.—Differences between program participants and comparison group on mean scores for recovery capital survey items

Recovery Capital Survey Items	Participant Group (n=22)	Comparison Group (n=18)	Difference
There are more important things to me in life than using substances.	4.38	3.94	0.44
In general, I am happy with my life.	3.77	3.50	0.27
I have enough energy to complete the tasks I set for myself.	4.00	3.67	0.33
I am proud of the community I live in and feel a part of it.	3.95	3.22	0.73*
I get the support I need from friends.	3.50	2.94	0.56
I get the support I need from family.	3.55	3.44	0.10
I regard my life as challenging and fulfilling without the need for using drugs or alcohol.	4.18	3.72	0.46
My living space has helped drive my recovery journey.	3.77	3.27	0.49
Since entering recovery, I take full responsibility for my actions.	4.50	3.78	0.72*
I am happy to deal with a range of professional people.	4.04	3.72	0.32
I am making progress on my recovery journey.	4.45	3.67	0.79*

Source: Program Participant Survey and Comparison Group Survey
Note: Scale ranges from 1 (strongly disagree) to 5 (strongly agree). The comparison group was restricted to survey respondents who did not report getting recovery coach services.
*p<.10 from Mann-Whitney U test

The findings from the interview/focus groups complement the survey findings. The program participants spoke to the personal capital they gained through recovery coaching. This included **basic household items**. One participant stated that if you do not get something, it is because you did not ask for it. For example, she gets items such as trash bags and dish soap and does not feel embarrassed asking for help. Four program participants discussed **gaining employment**, with two participants becoming recovery coaches.

Four participants spoke about the **improvement in their quality of life**. One participant shared that when he came to the organization, he was homeless, about to lose his family, and addicted to heroin. When he first came in, his pants were too big and as time went by he grew into them. Now he practices better hygiene and is starting to have confidence in himself. It was because of seeing people around him do that—it inspired him. He now has his home and family back. He even has a bank account, which he never had before. As he said:

> *I came here and slowly but surely, I started to change. … And now I'm starting to come into confidence with myself and that was because I was watching other people here model that behavior. I got my family back, I moved into a home, and that's a wonderful thing.*

Another participant shared that she is back in school for criminal justice, concentrating in human services. She feels that she is improving every day, remarking:

> *My quality of life has increased. I'm happier. I can problem-solve on my own. Sometimes I still need help problem-solving, but at least I know where to go to get help with my problems.*

Program participants referenced **improved self-esteem**, **increased knowledge**, and an **increased ability to navigate challenges**. A participant shared that he now can speak to people about anything he needs to work through. He also works in the garden and that gives him hope because he gets to see the resilience of the plants and sees how he can implement that in his life. Another participant shared that recovery coaching taught her structure and boundaries as well as how to love herself in order to love others. She was scared when she first came but now feels like she's moving in the right direction—"the direction God has for her life." One participant shared that she did not even know if she liked herself. She is now diagnosed with PTSD and knows she has trauma—and this actually helps her live life. She knows now how to deal with people, with men, and with sexual protection. She knows she has a safe place to go and a safe line to call if she gets hurt.

> *You may not get the answer you want, but you get the answer you need.*
>
> Program participant

Other physical and human capital outcomes included **improved health and housing**, **feeling happy and hopeful again**, and **healing**. A participant shared that his recovery coach is the reason that he is here today. He was shot in 2019 and they encouraged him and told him "when you get through healing, you come back and we're going to be here for you." He also stated that they have availability for people who need immediate help because they are dealing with drug problems and trauma. One participant announced "210 days sober" and received a round of applause from the group. Another participant stated that the organization calls her on her "clean date" every year and celebrates with her.

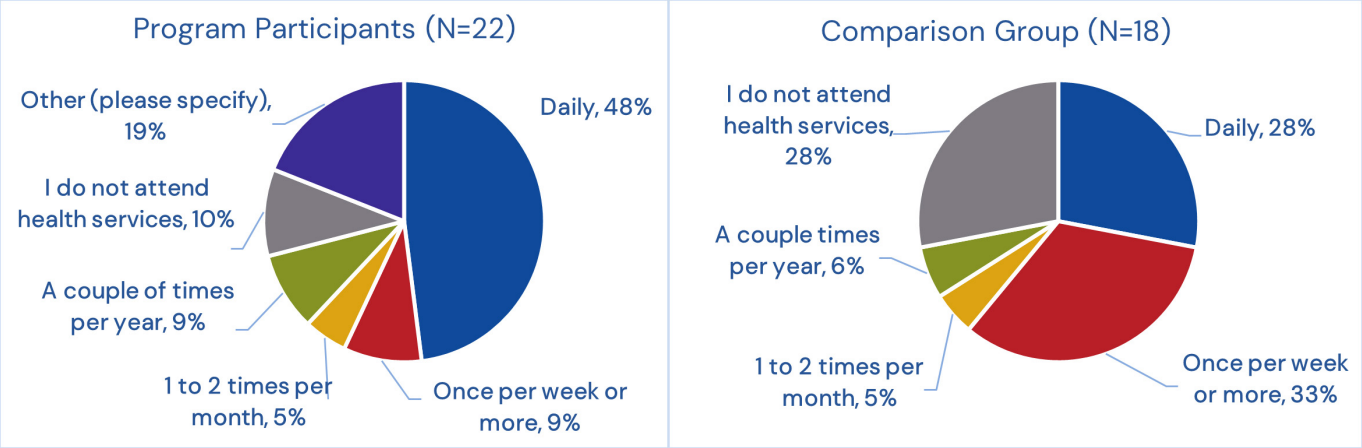
Program participants also reported that they found a **community** and had **strong relationships** after joining their recovery program. Five participants referred to the people in the organization as their family. One participant said, "Everyone is like a family," adding:

> *I went back into a dark place in my life and I thank God for Above and Beyond because it was the people I had built relationships with here that reached out to me and called me and said I was worth saving.*

Physical and Behavioral Health Service Attendance

To examine how recovery coaching changed participant behavior, the reported use of physical and/or behavioral health services was compared between program participants and comparison group members. The survey asked respondents how often they used physical and/or behavioral health services on average since entering recovery (exhibit 5-6). Larger percentages of program participants (48 percent) reported using services daily compared to comparison group members (28 percent). A larger percentage of comparison group members reported that they do not attend health services relative to program participants (28 percent versus 10 percent, respectively). However, the mean score difference between the two groups was not statistically significant, and the small sample sizes warrant caution in the interpretation of these results.

EXHIBIT 5-6.—Differences between program participants and comparison group in use of physical and/or behavioral health services



Sources: Program Participant/Comparison Group Survey, question 13: "Since entering recovery, how often have you used physical and/or behavioral health services on average?"
Note: Sample includes 22 responses from program participants and 18 responses from comparison group members.

Substance Use

Another behavioral indicator was substance use. Reported use of opioids in the past 30 days was compared for program participants and comparison group members. Seventy-seven percent (*n*=17) of program participants and 83 percent (*n*=15) of comparison group members reported never using opioids in the last 30 days. Fourteen percent (*n*=3) of program participants and 11 percent (*n*=2) of comparison group members reported using opioids at least once per day in the last 30 days. None of these between-group differences were statistically different. In addition, these results do not account for whether and how participating organizations offer harm-reduction services that include taking opioids for pain management, which could account for reported use of opioids in the past 30 days among both program participants and comparison group members.

Satisfaction with the Program

Program participants were asked to rate their satisfaction with their program. Overall, program participants had favorable ratings:

- 77 percent of survey respondents were "very likely" to recommend the program to another person who uses opioids and 10 percent were "likely" to recommend the program
- 80 percent of survey respondents rated the quality of services received with their organization as "excellent" with the remaining 20 percent rating the quality as "good"
- 87 percent of survey respondents rated the quality of services provided by their recovery coach as being the highest quality

Evaluation Capacity Building

Evaluation capacity building sessions were provided by ICF over the course of 12 hour-long virtual meetings delivered monthly between December 2021 and November 2022. Designed to enhance participants' capacity as educated consumers of evaluation, these sessions were divided into three modules: (1) Planning Evaluation; (2) Implementing Evaluation; and (3) Reporting and Using Evaluation. The curriculum was based on the AmeriCorps evaluation capacity building core curriculum with extensive tailoring to the participating organizations' contexts. Sessions included a mix of Microsoft PowerPoint presentations and demonstrations, whole group discussions and activities, and breakout discussions. Participants' contributions, especially responses to and insights about discussion questions and report-outs from break-out rooms, were recorded by a note-taker.

In total, 16 representatives from the participating organizations (e.g., project directors, organization staff, partners) participated in the evaluation capacity building sessions, ranging from one to seven representatives from each of six organizations that were participating in the evaluation as of December 2021. As described in Chapter 2, there was some attrition in organization participation in the evaluation and this was observed in the evaluation capacity building as well; among two organizations that eventually dropped from the evaluation, those organization representatives were also absent from most evaluation capacity building sessions, particularly in the latter months in which sessions were delivered.

The evaluation capacity building sessions were designed to complement the bundled evaluation in ways to support immediate and long-term evidence building for the recovery coaching model. First, in the short term, the evaluation capacity building helped participants stay engaged with the bundled evaluation. Every session included discussion prompts that encouraged participants to draw connections between evaluation concepts presented in the session and their own experiences participating in the bundled evaluation or other evidence building activities. Additionally, there were three sessions specifically designed to elicit participants' feedback on the bundled evaluation, such as their input on data collection activities in their context. By fostering participant engagement and feedback, evaluation capacity building sessions strengthened the bundled evaluation and the evidence it produced. Second, the evaluation capacity building supported participants' knowledge and confidence in evaluation topics, and thus served to empower participating organizations to generate future evidence on recovery coaching in the long term by planning and implementing evaluations in their own specific contexts going forward.

A mixed-methods evaluation of the evaluation capacity building sessions was conducted to achieve two primary objectives: (1) to provide formative feedback to help enhance the curriculum and delivery of the sessions to better align with participating organizations' needs, and (2) to provide summative feedback regarding the degree to which the sessions led to changes in participants' knowledge of and attitudes toward evaluation. Data sources for the evaluation included the following:

- A session-specific post-survey administered at the conclusion of each presentation. Results from these surveys were used to calculate a composite satisfaction rating on a 1–5 scale for each session and assess participant knowledge of session content. The post-session surveys also included open-ended opportunities for participants to describe what they liked and what could be improved in the session's content or delivery.
- Direct observations of all sessions.
- A pre- and post-survey that assessed participants' knowledge of and attitudes toward evaluation topics at the beginning and conclusion of the entire curriculum.

Satisfaction with Evaluation Capacity building Sessions

In general, participants were very satisfied with the learning experience provided through the evaluation capacity building sessions. All sessions had a mean satisfaction rating higher than 4, including four sessions for which all participants provide a satisfaction rating of 5: Preparing to Collect Data; Connection to the Bundle Evaluation; Evaluation Reporting; and Using Evaluation for Program Improvement and Continuous Learning (exhibit 6-1). In open-ended responses, participants said these sessions provided the most tangible content they could immediately apply in their context. They also liked the opportunities to get their colleagues' feedback on their own challenges or approaches related to these topics during discussion activities.

EXHIBIT 6-1.—Satisfaction with evaluation capacity building sessions

Session	Mean Satisfaction (1-5)
Introduction and Evaluation Basics	4.21
Getting to Know One Another	4.48
Theories of Change	4.13
Logic Model	4.42
Evaluation Planning	4.29
Preparing to Collect Data	5
Connecting to the Bundled Evaluation	5
Data Collection Techniques	4.6
Data Analysis	4.75
Evaluation Reporting	5
Using Evaluation for Program Improvement and Continuous Learning	5
Interpreting Data from the Bundled Evaluation	4.5

Insights into Recovery Coaching Evaluation Challenges and Opportunities from Session Discussions

Every session included opportunities for participants to discuss their evaluation challenges and opportunities. Key insights from these discussions included the following:

- Many participants felt their existing theory of change did not fully capture the contextual factors influencing their program, or clearly articulate the effect on AmeriCorps members themselves.
- Participants commented that their program models often pose data collection challenges, especially because their intended beneficiaries are often difficult to reach and reluctant to share information on a survey or focus group. Participants said they appreciated learning from their colleagues about data collection strategies, especially those that minimize respondent burden and/or capitalize on administrative data they already collect.

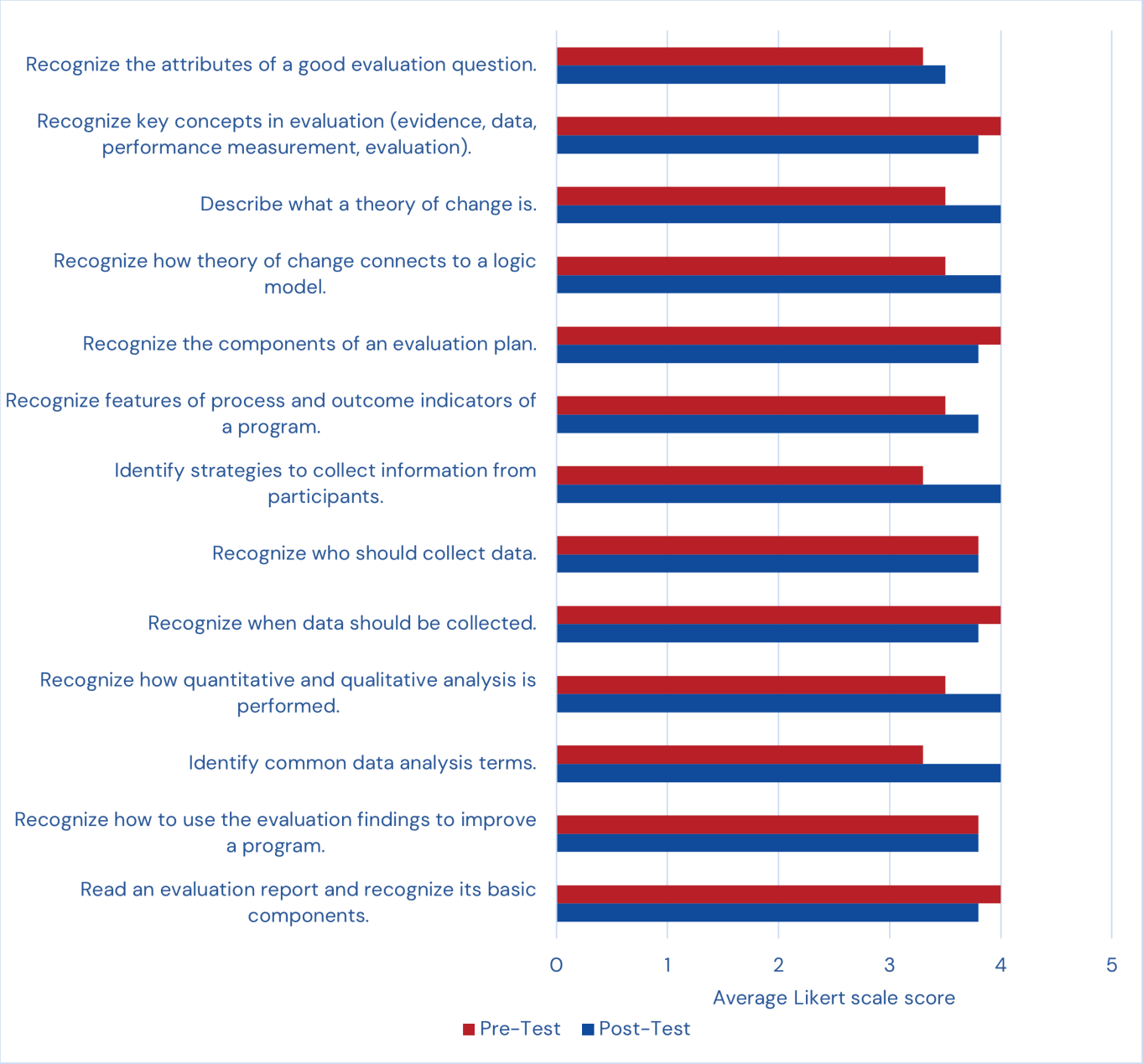
- Participants commented that client narratives and case notes often contain rich data, but they often struggle to analyze these data and feel these stories get lost. Participants commented that surveys or output measures such as number of clients served miss the full picture of how recovery works, and they appreciated hearing from colleagues about how they capture their programs' impact.
- Participants observed that there is demand in their field for valid and timely evidence because finding the right approach is a matter of life and death for their beneficiaries. Consequently, program administrators value evaluation and evidence, but desire tangible findings that can be quickly put into practice.

Outcomes

The evaluation examined outcomes across five domains: perceived knowledge of evaluation topics; use of evaluation behavior and evaluation-related skills; attitudes toward evaluation; motivation to conduct evaluation; and barriers to evaluation.

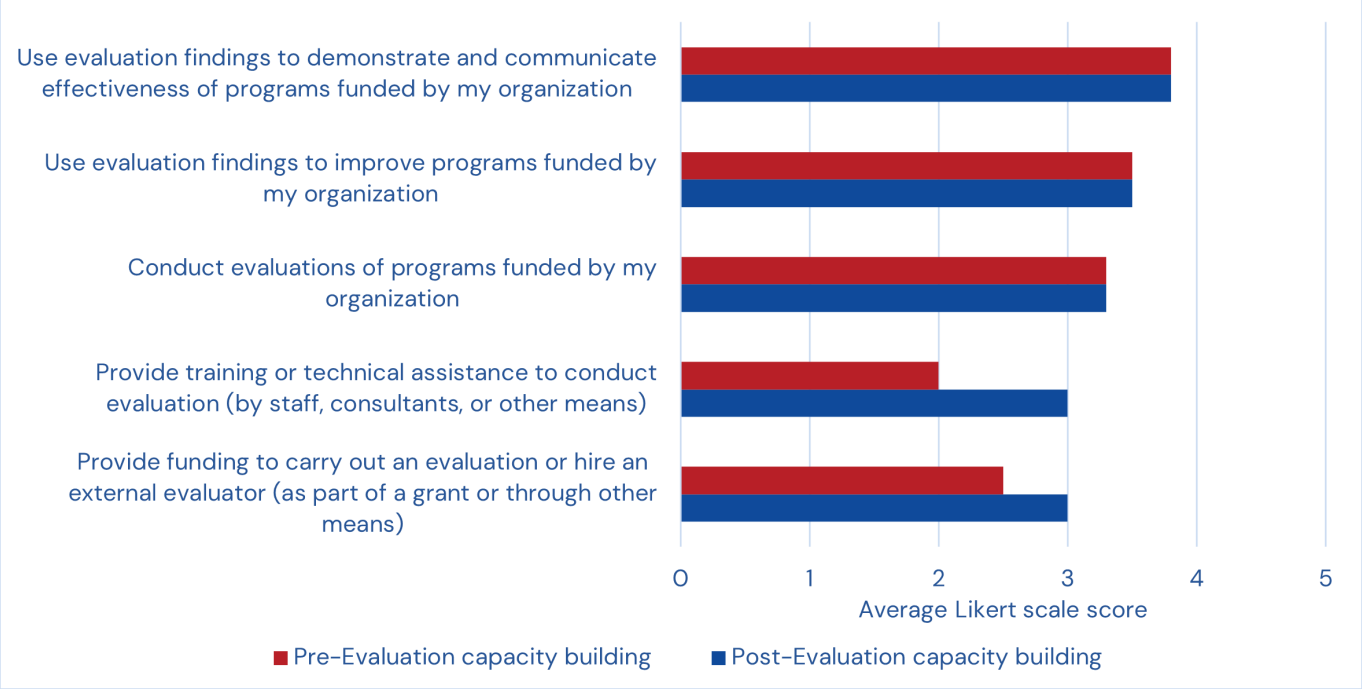
Perceived knowledge of evaluation topics. Participants' perceived knowledge of evaluation topics increased across seven out of thirteen topics measured on the pre-post survey (exhibit 6-2). The topics on which participants' perceived knowledge increased the most were recognizing what a theory of change is, recognizing how a theory of change connects to a logic model, and recognizing how quantitative and qualitative analysis is performed.

EXHIBIT 6-2.—Participants' perception of their knowledge of evaluation topics



Use of evaluation behavior and evaluation-related skills. Participants' self-reported use of evaluation behavior increased on two topics included on the pre-post survey: their perceived ability to provide training or technical assistance to conduct evaluation and their perceived ability to engage an external evaluator (exhibit 6-3). There was no change in their perceived skill on the other three topics on the survey.

EXHIBIT 6-3.—Participants' perception of their evaluation-specific skills

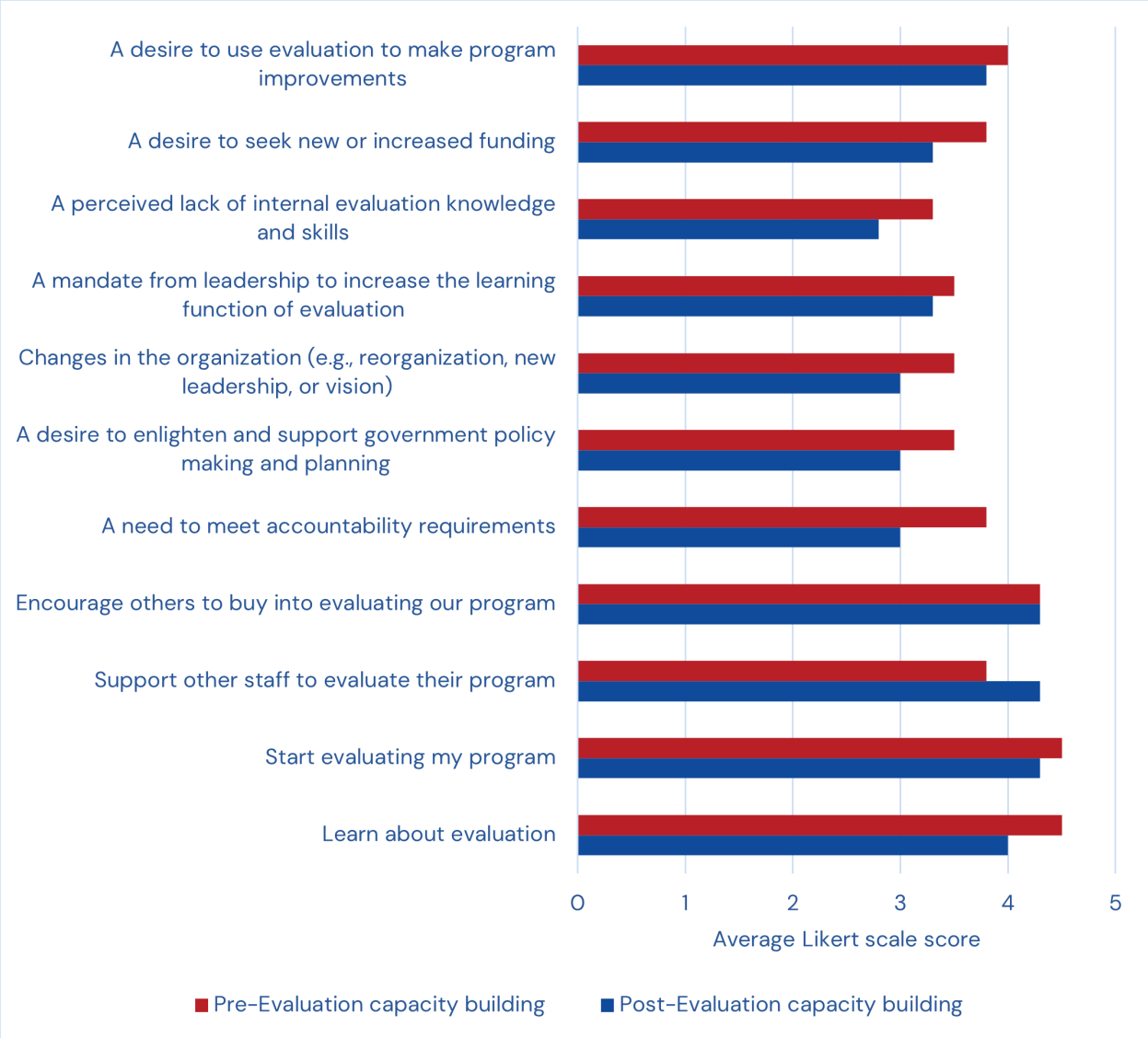


Attitudes toward evaluation. Evaluation capacity building participants rated their agreement on 10 statements about evaluation in the pre-post survey. These statements included a mix of positive and negative sentiments, such that in some instances agreement indicated a positive attitude toward evaluation and on others disagreement with the statement signaled a positive attitude toward evaluation. On eight of the ten items, changes from pre to post indicated more positive attitudes toward evaluation, with the largest positive change associated with the statement "Evaluation will inform decisions I make about my program" (exhibit 6-4). However, on two items, attitudes toward evaluation were more negative on the post-survey compared to the pre. These were "Evaluation takes away resources more than can be used to provide services" and "Evaluation will improve services to target populations."

EXHIBIT 6-4.—Participants' attitudes toward evaluation

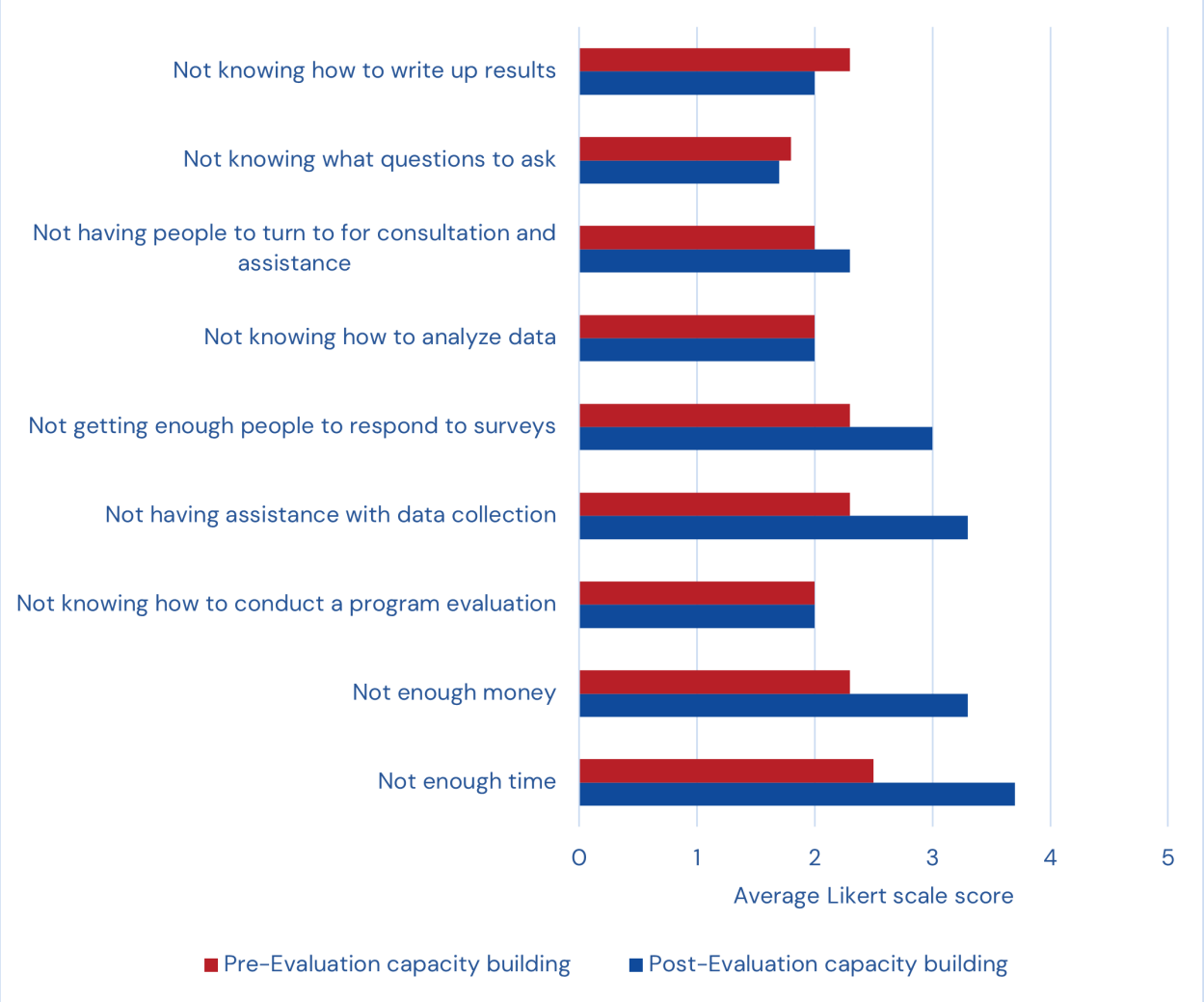
Motivation to conduct evaluation. Before the evaluation capacity building series, participants were most motivated to encourage others to buy into evaluating their program, learn about evaluation, and start evaluating their program (exhibit 6-5). After the evaluation capacity building series, participating organizations' motivation to conduct evaluation or engage with evaluation generally seemed to decrease across all but two of the statements related to their motivation to conduct evaluation. These were to "encourage others to buy into evaluating their program" and to "support other staff to evaluate their program."

EXHIBIT 6-5.—Participants' motivation to conduct evaluation



Barriers to evaluation. The biggest barrier to evaluation before evaluation capacity building was the time required to conduct an evaluation (exhibit 6-6). This remained the biggest barrier after the series. The only barriers that showed a decrease in importance through the series were not knowing how to write up an evaluation (this barrier showed the greatest decrease) and not knowing what questions to ask.

EXHIBIT 6-6.—Participants' barriers that prevent engaging in evaluation



Discussion and Next Steps

The United States is facing an unprecedented addiction and overdose epidemic. In 2017, the U.S. Department of Health and Human Services declared a public health emergency in response to the increasing number of opioid-related overdoses and deaths. President Biden has declared the administration's commitment to addressing addiction and the overdose epidemic (The White House, 2022), and the efforts of federal agencies such as AmeriCorps are critical to successfully undertake this national priority. Between FY 2017 and FY 2022, AmeriCorps invested over $129 million to fund projects addressing opioid addiction and other SUDs. One promising strategy to address the rising rates of SUDs and drug overdose is recovery coaching through AmeriCorps members. According to Zandniapour and colleagues (2020), using AmeriCorps members as recovery coaches would extend the mission of AmeriCorps "using service as an avenue of recovery and expansion of recovery services for both the individual and the communities who are served" (p. 7).

This report presented the implementation (context, models, operations, activities, services, and supports) and outcomes of the AmeriCorps-funded recovery coach programs, as well as findings from the evaluation capacity building delivered to participants in the recovery coach evaluation. This chapter summarizes these findings. It highlights the limitations of the study and also presents the next steps for the recovery coach bundled evaluation.

Findings on Program Implementation

Recovery Coach Models, Activities, and Services

Overall, participating organizations' recovery models incorporated similar components to meet the needs of their participants. ***Lived experience*** is a crucial pillar of participating organizations' use of peer recovery coaching models. All participating organizations require recovery coaches to have lived experience and be in recovery. Survey respondents emphasized the importance of lived experience, with 86 percent of recovery coaches stating it affects relationship building with clients/peers. Site visit participants also stressed the importance of lived experience, emphasizing empathy and having experienced similar challenges as the participant. Active addiction is a lonely place, and having a recovery coach who understands their situation builds trust and rapport between coach and participant.

Participating organizations strive to provide ***culturally appropriate services*** to their participants by hiring individuals who represent the communities they serve and providing continuing education to develop culturally appropriate styles of interacting with peers (LGBTQIA+, Hispanic/Latino, etc.). Programs offer culturally responsive treatment environments in areas such as evaluation and monitoring, client treatment planning, organizational values, infrastructure, and workforce and staff development. Despite offering culturally responsive treatment plans, only 60 percent of project directors reported that racial, ethnic, and cultural identities were incorporated into treatment plans. While project directors perceived the services to be culturally appropriate, 87 percent of surveyed recovery coaches and 74 percent of program participants found that the services reflect their culture or worldview completely or very well.

Participating organizations also include ***harm-reduction strategies***, such as providing Narcan and needle exchanges, and meeting participants where they are.

Holistic care is a common program component among participating organizations, focusing on assisting participants in building their lives into their desired self. This holistic approach includes in-house services and referrals for personalized services. For example, recovery coaches connected participants to a variety of personalized supports. These included education services, emergency shelters, employment services, food

services, housing services, legal services, and physical or behavioral health providers. They also provided a range of services that are not directly recovery-related, including supports for transportation, basic provisions (e.g., food, clothing), life skills, art therapy, and other classes (e.g., dance, yoga).

All participating organizations worked with other organizations and/or providers in their area to facilitate client referrals for additional services. The referrals for services mainly fell into two categories: medical services (e.g., detoxes, checkups, screenings, therapy) and supportive services (e.g., housing, financial support, meals, clothing, employment). Some participating organizations had over 100 linkage agreements for various services. If a program does not provide the necessary services, they connect participants with other organizations for supplemental services. Resource lists are available for program participants, and enrichment classes and training are provided for recovery coaches. Participating organizations developed partnerships through broader statewide coalitions, coordinating with local universities and employers, conducting online research, and posting on social media. In addition, one participating organization has as part of their AmeriCorps VISTA's position description conducting community outreach and link resources.

During the COVID-19 pandemic, participating organizations faced challenges in providing in-person services and resources. Three participating organizations temporarily discontinued in-person services, while one remained open throughout 2020 and 2021. They used various measures to protect against COVID-19, including masking, temperature checks, social distancing, and outdoor services. Participating organizations also provided resources such as food drop-offs, laundry money, and basic provision deliveries. Virtual services were made possible by procuring special grants for computers, tablets, phones, or Wi-Fi hotspots. However, in-person services were preferred by most interviewees as recovery coaching relies on human connection and relationship building. Participating organizations plan to continue providing virtual services or a hybrid model but prefer in-person services to foster trust and rapport among coaches and participants.

Recovery Coach Identification, Recruitment, and Training

Participating organizations use various methods to recruit potential recovery coaches, including their own programs, community recovery programs, schools, universities, job sites such as Indeed, online recovery networks, and personal connections. In addition to lived experience, preferred characteristics for a recovery coach included compassion, listening and communication skills, patience, establishing boundaries, and computer skills. Hiring requirements vary across participating organizations, with some hiring individuals who are in training to obtain state certifications, while others require certification through the state before hiring. The required amount of sustained recovery time varies by organization, with some requiring 1 year of sustained recovery, while others require 2 years.

Participating organizations identified two challenges to recovery coach recruitment and hiring. The criminal history background check was identified as a barrier to hiring recovery coaches. Three project directors noted that failing the background check can be problematic when hiring recovery coaches because they expect a certain level of justice involvement. AmeriCorps is open to members with some level of justice involvement if they are honest about it. However, members with some level of justice involvement are often denied based on the background check, which can be a problem when the organization likes a candidate. The stipend was also identified as a barrier to recruitment and hiring. AmeriCorps members noted that the stipend amount was not sufficient.

Participating organizations require organization-specific training in addition to state certification training. The certification requirements for recovery coaches vary by state. The certification process includes a requisite number of hours of education/training, work experience, supervised work, and a certification exam.

Participating organizations also require organization-specific training for recovery coaches and other staff. Most director survey respondents reported an onboarding process for recovery coaches. Most recovery coaches reported receiving 17 or more hours of training, primarily conducted by someone outside of the organization, with 66 percent using a specific curriculum or manual. All recovery coaches found the training helpful.

Peer Support

The recovery coaches play a crucial role in supporting program participants in recovery from SUDs and mental health diagnoses. They provide emotional, informational, affiliational, instrumental, and mental health support to help participants navigate their recovery journey**.** ***Emotional support*** involves listening to program participants, showing concern, and providing empathy. Recovery coaches often use their personal experiences to develop trust and provide emotional support. They help participants feel heard and understand that every addiction is different, helping them find their own path to recovery.

Informational support is essential to connect participants to community resources and share knowledge and information. ***Instrumental support*** is another key aspect of recovery support, providing concrete support to accomplish a task. Recovery coaches provide referrals to outside services, such as employment services, food services, emergency shelters, and physical or behavioral health providers. They also provide tangible services, such as assisting participants with housing, food pantries, counseling services, legal services, and employment.

Recovery coaches provide connections to recovery community supports, activities, and services (known as ***affiliational support***), such as NA or AA. They also provide ***mental health support***, assisting individuals with mental health diagnoses, such as PTSD, depression, or anxiety. Some coaches collaborate with AmeriCorps members to address the mental health needs of program participants who are victims of trauma. Other participating organizations have groups specifically designed to help participants overcome trauma.

Challenges and Solutions

Working with individuals with SUDs can be emotionally challenging. Recovery coaches identified incidents of overdose and lack of participant readiness as challenges. The role of a recovery coach is emotionally intense, and it is essential to understand that not everyone is ready to engage in recovery. Many program participants have mental health diagnoses and trauma, making the recovery coach's role challenging. One recovery coach struggled with implementing harm-reduction strategies in their area as people had misconceptions about the strategies. Another recovery coach struggled with cultural differences between the program participants and himself despite the participating organization's attempt at culturally responsive treatment. While managing these challenges, recovery coaches continue to work on their own recovery and provide support for participants in the early stages of recovery.

All participating organizations have monitoring and oversight plans for recovery coaches. Two participating organizations, Healing Action and Recovery Corps, have implemented regular check-ins with their coaches to address self-care practices and vicarious trauma. These methods help identify potential issues before they significantly affect the coach's work. All participating organizations report that the organization provides opportunities for recovery coaches to connect with each other. This provides a mechanism through which struggling recovery coaches can get additional support to maintain their own recovery while still providing support to other program participants. Recovery coaches report receiving support from other coaches and from leadership at their organization and that the support helped them to perform their job as a recovery coach.

Perceived Outcomes

Participating Organizations

Participating organizations reported improved organizational capacity to provide services, leveraging grant support, and collaborating with partners and community resources. All project directors agreed that their programs have the organizational capacity to provide services. The interviews with project directors corroborated the survey results. Participating organizations such as Healing Action and AnB have seen increased services provided by AmeriCorps members, who bring new experiences and ideas. These members help expand the organization's capacity into rural areas, break down communication barriers, and improve visibility. Additionally, AmeriCorps supported Recovery Corps' scaling of recovery coaching to Illinois, California, and Virginia.

All project directors agreed that their programs can leverage grant financial support. They receive additional funding from private and public (including federal) organizations. The participating organizations also agreed that their programs collaborate with partners, organizations, and community resources. As discussed above, all participating organizations worked with other organizations and/or providers in their area to facilitate client referrals for additional services. The program models are holistic, with partners providing medical services and supportive services that the programs are unable to provide.

Recovery Coaches

Recovery coaches reported increased knowledge, improved attitudes, and improved behaviors as well as increased opportunities for maintaining their own recovery. Over 80 percent of recovery coaches report that their confidence, self-esteem, and self-management have increased since becoming a coach. Coaches also report that their ability to help individuals with opioid addiction and their own ability to stay in recovery has increased. Overall, recovery coaches receive satisfaction from improving the health of their community and helping people with opioid addiction enter long-term recovery.

Recovery coaching plays a critical role for coaches to maintain their recovery. Recovery coaches serve as role models for program participants. One coach believed that being a coach has helped her reflect and maintain accountability in her recovery, stating, "I believe this job helps hold me accountable because if I am on the phone giving advice … I better be taking a hard look in the mirror and following my own advice." Another coach praised the coaching model, stating that it helps him stay in recovery and gives him a sense of purpose: "It's not just important for getting more people into recovery; it's so important for maintaining long-term recovery as well."

Program Participants

Program participants reported increased recovery capital, increased attendance to more physical and behavioral health services, and decreased incidence of substance use. This study assessed the self-reported recovery capital of program participants. The highest levels of reported recovery capital among program participants were with the items "Since entering recovery, I take full responsibility for my actions" (91 percent); "There are more important things to me in life than using substances" (86 percent); "I am happy to deal with a range of professional people" (82 percent); and "I am making progress on my recovery journey" (91 percent). The lowest agreement was the item "I get the support I need from friends" (55 percent). During the interviews and focus groups, the program participants discussed personal capital gained, including gaining employment (four participants), improved quality of life (four participants) improved self-esteem (four participants), increased knowledge (two participants), and an increased ability to navigate challenges (three participants). They shared that recovery coaching taught them how to create structure and set boundaries as

well as how to love oneself in order to love others. Other physical and human capital outcomes included improved health and housing, feeling happy and hopeful again, and healing. Program participants also reported finding a community and having strong relationships since joining their recovery program.

To understand what would happen in the absence of recovery coaching, the recovery capital outcomes of program participants were compared to comparison group members. Program participants had higher agreement with all recovery capital survey items, with marginally significant between-groups differences for three items: "I am proud of the community I live in and feel a part of it"; "Since entering recovery, I take full responsibility for my actions"; and "I am making progress on my recovery journey." Future studies should seek to replicate these findings in larger and more representatives study samples.

To examine how recovery coaching changed participant behavior, the reported use of physical and/or behavioral health services was compared between program participants and comparison group members. Larger percentages of comparison group members (75 percent) reported using them daily or at least once per week compared to program participants (60 percent). A larger percentage of program participants reported that they do not attend health services relative to comparison group members (20 percent versus 13 percent, respectively), however no data were provided in site visits or surveys that might explain a reason for this finding. This analysis should be interpreted with caution due to the small sample size.

The final analysis compared reported use of opioids in the past 30 days. Most program participants (77 percent) and comparison group members (83 percent) report no opioid use, but participating organization programs offer harm-reduction services that include taking opioids for pain management. This may account for program participants' reported use of opioids in the past 30 days.

Evaluation Capacity Building

Participants liked the pairing of evaluation capacity building with the bundled evaluation, especially for the opportunities it provided to discuss their program challenges as well as opportunities for building evidence. In general, participants were very satisfied with the learning experience. All sessions had a mean satisfaction rating higher than 4 on a 1-5 scale, including four sessions for which all participants gave a satisfaction rating of 5: Preparing to Collect Data, Connection to the Bundle Evaluation, Evaluation Reporting, and Using Evaluation for Program Improvement and Continuous Learning. In open-ended responses, participants said evaluation capacity building included tangible content they could immediately apply in their context. They also liked the opportunities to interact with others working in this space, especially to discuss challenges and opportunities for building evidence in this space.

Participants increased their knowledge of evaluation topics and had more positive attitudes toward evaluation. Participants' perceived knowledge of evaluation topics increased across seven out of thirteen topics as measured on the pre-post survey. The topics for which participants' perceived knowledge increased the most included: recognizing what a theory of change is, recognizing how a theory of change connects to a logic model, and recognizing how quantitative and qualitative analysis is performed. On eight of the ten items measuring attitudes toward evaluation, changes from pre to post indicated more positive attitudes toward evaluation, with the largest positive change associated with the statement "Evaluation will inform decisions I make about my program."

Participants reported greater confidence in evaluation-related topics after the sessions. Participants reported more confidence in their ability to train their staff on evaluation topics and engage effectively with an external evaluator. Specifically, participants reported improved ability to know which questions to ask and how to write about evaluation findings.

Discussion

The implementation findings from this study corroborated the existing literature on recovery programs. The current study found that lived experience is a crucial pillar of all recovery coach models because it affects relationship building between recovery coaches and program participants. This finding on the importance of lived experience adds support to the growing research literature (Kawasaki et al., 2019; Zandniapour et al., 2020). A challenge associated with lived experience, however, is that having an SUD may have led to previous involvement with the criminal justice system, posing a potential barrier to hiring due to the criminal background check. As illustrated above, program models and activities had common elements; however, the participating organizations provided individualized activities and services that were geared to the populations served and their respective settings. State policies—from harm-reduction services to behavioral health services for Medicaid enrollees (Guth, 2021) and more—are also a contextual factor in shaping how and what services are delivered to participants in recovery coaching programs. This is comparable to the literature that noted services vary due to the program setting and populations of focus (Eddie et al., 2019). While most of the research focuses on a recovery-oriented culture (e.g., Chapman et al., 2018), studies that examined culturally appropriate services were not found. The current study provides new information on how recovery coach programs try to include culturally appropriate services into the organization and treatment plans for individuals.

This study provides important information for understanding how AmeriCorps projects provided recovery coaching services. While important limitations affect the generalizability and interpretability of some findings, the study generally found successful recovery coach program implementation by participating organizations as well as reports of favorable outcomes by participating organizations, recovery coaches, and program participants. The findings reported here lay the groundwork for more investigation into the effects of recovery coaching programs, and recommendations for future work are discussed below.

This study found that participating organizations implemented recovery coach programs designed to meet the needs of the populations served and that participants had favorable perceptions of the recovery coach services. In addition, participating organizations, recovery coaches, and program participants reported favorable outcomes. Since a subset of recovery coaches and program participants agreed to participate in this study, the findings may not be representative of all recovery coaches or program participants at the participating organizations.

To improve our understanding of the effects of recovery coaching, a comparison of outcomes among those with and without recovery coaching services would be valuable for future work. While the evaluation detailed in this report had planned such a comparison, logistical limitations did not allow for robust investigation of a comparison group. Originally, the study team had distributed surveys for program participants and comparison group members identified in advance by participating organizations in a list provided prior to survey launch in November 2021. However, one participating organization sent the survey link to individuals who did not receive any services from a recovery coach and another provided the names of individuals who only met with a recovery coach once. There was a question on the comparison group survey that asked if the individual was receiving recovery coach services, and not all responses aligned with the list provided beforehand. Ultimately, respondents were classified as program participants (i.e., receiving recovery coaching services, n=22) or a comparison group (i.e., not receiving recovery coaching services, n=18) based on their self-reported response to that question on the survey.

This evaluation required collecting data from a vulnerable, hidden population (individuals with SUDs). In the recruitment calls at the start of the evaluation, staff from several AmeriCorps projects were hesitant and

wanted to protect the confidentiality of individuals being served. They did not want to share the names and contact information for their program participants and declined to participate in the evaluation. For those who agreed to participate, the survey was administered in multiple formats with a personalized identifier to protect the privacy of their program participants. Paper surveys were sent to one participating organization and survey links to other participating organizations. This resulted in a loss of information about the number of individuals who received the surveys and affected the ability to calculate response rates.

The response rates for the recovery coach and program participant surveys were low, and unable to be accurately determined. The study team planned to collect data using a baseline survey and a follow-up survey 1 year later to compare changes in outcomes over time. The baseline survey was launched in November 2021 and remained open until March 2022. Reminders were sent; however, only 67.5 percent of recovery coaches and 32.6 percent of program participants completed the survey during the first wave. The follow-up survey was sent to all individuals rather than solely those who completed the baseline survey due to the low response rates. The response rate was still low, with only 28.1 percent of recovery coaches and 7.8 percent of program participants completing the survey in the second wave. However, these numbers do not account for the total number of surveys distributed directly by the participating organizations, and an overall response rate cannot be determined. Sample attrition and low response are known barriers in the substance use research space, and several challenges to this specific evaluation have been identified.

The necessity of recruiting participating organizations' help at the time of specific data collection procedures (e.g., baseline surveys) created a narrow channel for success; in addition to the confidentiality concerns, there was also deadline pressure to recruit and collect data via the project directors. Future evaluations can explore strategies to mitigate these limitations, for instance by creating opportunities to obtain informed consent directly from potential participants (e.g., program participants and recovery coaches). One strategy may be to conduct site visits in the early stages of organizations' participation that include information sessions for project directors, coaches, participants, and comparison group members about the evaluation—this can include motivating its importance, its objectives, incentives for participation, and steps taken by study staff to ensure confidentiality and data security. Institutional Review Board approval can accommodate more open-ended recruitment strategies, for instance listing all potential study procedures (e.g., surveys, focus groups) in the informed consent that allows study staff to contact individuals for the specific study procedures that continue to apply on an individual basis. Giving potential participants early opportunities to become familiar with the evaluation, to provide informed consent, and to ask questions, may increase study participation rates while also relieving the burden on project directors to administrate study procedures (e.g., distribute surveys). Alternatively or complementarily, participating organizations can be provided with a simple information sheet to pass on to potential participants, and modern technology (e.g., QR codes) can allow potential participants to connect directly to study information and to contact study staff to express interest or to ask questions. Such steps to expose populations of interest in advance of study procedures may alleviate confidentiality and time concerns associated with relying upon project directors to recruit and collect data. In a similar vein, organizations' concerns about confidentiality may suggest the need to communicate more with project directors about the steps evaluators/AmeriCorps have in place to secure privacy (e.g., anonymizing any quotations used in reports, data security procedures). Quelling concerns about privacy and confidentiality may encourage more invested recruitment and tracking efforts. Finally, improved incentivization may motivate greater participation and response, whether this entails compensation that is of greater monetary value or more germane to participants.

As noted, of the original eight organizations who agreed to participate in the evaluation, four organizations ultimately withdrew from the evaluation, either expressing concerns about maintaining the privacy of their

program participants or providing no explicit reason for dropping out. The pandemic undoubtedly placed strain on organizations and likely hindered the ability of some organizations and individuals to fully participate in the evaluation process as they focused on delivering core services amidst evolving public health guidance.

The pandemic also affected data collection by the study team. In-person interviews and focus groups were planned at each site; however, due to the pandemic, virtual interviews and focus groups were ultimately conducted. It was also difficult to recruit participants for focus groups. Project directors were provided with a form letter to let the participants know that the study team would be reaching out to them about the focus groups. Still, program participants from only one organization participated in the focus group. Individual interviews were offered as another option (only one program participant accepted). Recovery coaches who participated in the interviews were asked if they would assist with recruiting program participants for interviews. Program participants were offered $25 Amazon gift cards for participation in a focus group or interview, yet feedback from one recovery coach suggested that a gift card would not be an incentive for her participants without internal motivation to participate. Additional probing with participating organizations could seek to identify effective incentives and potential solutions to mitigate concerns (e.g., confidentiality) to improve participation rates.

Participating organization staff who participated in the evaluation capacity building sessions echoed some of the challenges faced by the evaluation team. In their sessions, they reported that their program models often pose data collection challenges, especially because their intended beneficiaries are often difficult to reach and reluctant to share information on a survey or in a focus group.

Some of the challenges and potential future directions for evaluation of recovery coaching warrant discussion. A key priority to further this work is rigorous measurement of program impact through recruitment of a valid comparison group (i.e., a subpopulation not receiving recovery coaching services). Well-known high attrition rates among study participants in substance use research, the intensive and acute nature of many recovery programs, and the high variability in treatment services provided across individuals and contexts all pose systematic barriers to rigorous research with comparison groups. Substance use treatment tends to be short-term and the time window for recruiting and collecting data is small. The lack of standardization in the way treatment services (including recovery coaching) are integrated across individuals creates challenges in identifying and maintaining a comparison group. For instance, an individual not engaged in recovery coaching (and therefore eligible for comparison analyses) may suddenly integrate that service, or individuals engaged in recovery coaching may cease attending sessions.

An impact study was limited by the small sample sizes. Participants self-reported whether they received recovery coaching, but the ability to link respondents to their full history of services received (including when and for how long) would improve the generation of a robust comparison group. Due to the barriers noted above, timely tracking of potential participants—including the services they receive and their prospective enrollment in any recovery coaching treatments—is critical to effectively engage a comparison group. Direct access to the participating organization's treatment population would expedite this tracking and ensure that the information and data are managed in manners compliant with institutional review boards and Health Insurance Portability and Accountability Act regulations (e.g., with informed consent, use of password-protected files, deidentifying survey data). A greater understanding of organizations' confidentiality concerns can help AmeriCorps to address those concerns and open up greater collaboration that allows for rigorous and effective program evaluation.

When looking for a comparison group for recovery coaching, the following suggestions are recommended. To the extent possible, access to individual-level data is needed to maximize the potential for a rigorous

comparison group. Intake assessments should include an evaluation of the history of treatment services for the individual, including any experiences with recovery coaching. These data, along with administrative records, can identify a subpopulation that is engaged with substance use treatment but not with recovery coaching. To reduce confounding, these data would need to include covariates based on theory/literature, such as demographic characteristics.

Given the barriers noted above, including high attrition rates, timely distribution of surveys would be critical for obtaining at least baseline data, and, hopefully, additional surveys to capture changes across time in both treatment and comparison populations. As mentioned, the appropriateness of comparison group characteristics is important to evaluate to increase confidence in isolating the effects of recovery coaching (as opposed to confounders). One potential source of confounding comes from self-selection bias in which those who seek recovery coaching may be fundamentally different than those who have yet to participate in, or who may actively avoid, recovery coaching. For instance, a key benefit to recovery coaching is the social connectedness and collaborative approach to recovery; it is plausible that those who may not choose to participate in more socially engaged treatment services (e.g., those who experience greater levels of anxiety in social settings) may be characteristically different from the treatment population. If waitlists for recovery coaching are in place, a waitlist control approach can abate self-selection bias concerns, for example by distributing surveys to those who express interest in recovery coaching (e.g., they have signed up for a session). Ethical considerations in delaying treatment options can inform whether or how this approach can be implemented. Researchers and the organizations can work together to identify a way to share individual-level data such that appropriate adjustments for confounders can be made in any statistical modeling to boost confidence in detecting effects from recovery coaching. Alternatively, participants from treatment sites that do not offer recovery coaching may act as a comparison site.

Finally, future work can consider the utility of dose-response or survival analysis analytical methodology (i.e., assess outcomes based on exposure to recovery coaching as a continuous measure), which would help clarify to what degree repeated exposure to recovery coaching sessions correlates with improved outcomes. Additionally, these methodologies may provide an alternative to using a comparison group, although tradeoffs in the interpretability of the results must be considered.

Next Steps

Given the small sample size of data collected for this study and the challenges faced by the programs due to the pandemic, a second cohort of organizations will participate in the bundled evaluation and evaluation capacity building. The participating organizations include both AmeriCorps State and National grants and AmeriCorps VISTA projects that received AmeriCorps funding in FY 2021 or FY 2022. Twelve participating organizations were invited to participate in the evaluation; nine accepted. As of September 2023, there are seven organizations participating in the bundled evaluation.

Surveys were launched for project directors, recovery coaches, AmeriCorps members, and program participants in February 2023. Site visits occurred in fall 2023. The results from the Cohort 2 study will be aggregated with the current study, with the goal of generating more robust and conclusive findings with a larger sample size.

In addition, ICF has partnered with one participating organization from the first cohort, Recovery Corps, to conduct additional analyses on a robust set of longitudinal administrative data collected by the organization on participants receiving support services from recovery navigators. Analyses will explore descriptive

comparisons of site-level characteristics (e.g., case load) as well as statistical inference testing on hypotheses on the beneficial effects of peer support services and various outcomes.

With these findings, AmeriCorps will continue to build evidence on best practices for recovery programs and explore how the agency mitigates SUDs and supports recovery through AmeriCorps projects. The goal is that findings will help to set standards and to shape the course of future recovery programs and other similar types of programs.

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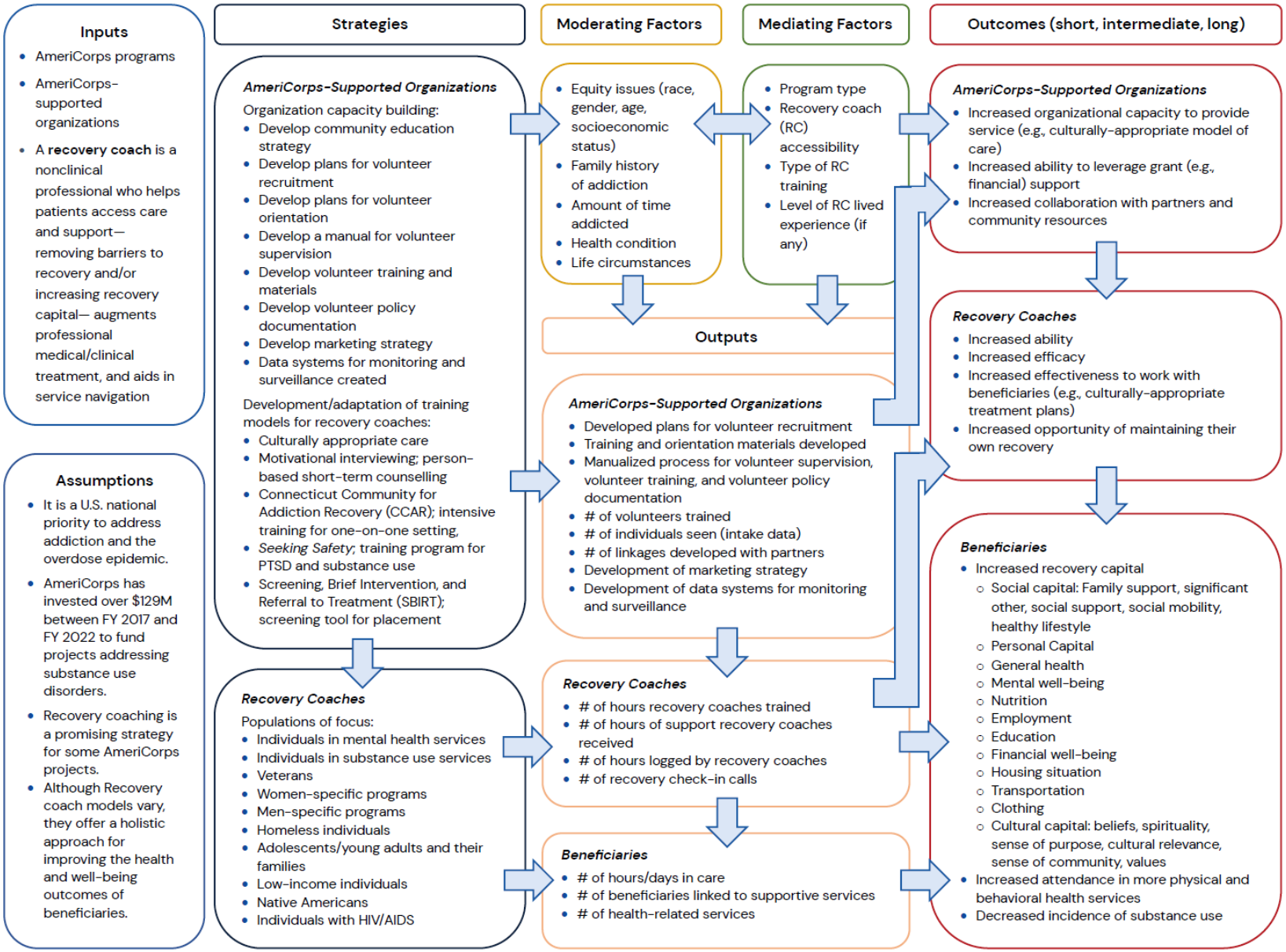
Appendix A. Logic Model



Appendix B. Participating Organization Site Profiles

Above and Beyond Family Recovery Center

Above and Beyond Family Recovery Center (AnB) provides addiction recovery services to everyone, including individuals who are unable to pay for them, along with supportive services, such as housing and employment assistance. Located in Chicago's East Garfield Park, AnB largely serves clients from Chicago, Ill., and neighboring suburbs, with most clients coming from Chicago's West Side. Because of their location, they target their services to low-income African American communities in Chicago's West and South Sides. They serve low-income individuals with disabilities, individuals and families experiencing homelessness, unemployed individuals, low-income adults, low-income formerly incarcerated adults, low-income communities, low-income veterans, and low-income military families. The organization has a history of serving very low-income individuals, many of whom are chronically homeless as defined by the U.S. Department of Housing and Urban Development. The majority of AnB's clients identified as male, nearly half of all intakes were under the age of 40, and about 70 percent of patients were Black. During intake with AnB, over one-third of clients indicated no annual income.[8] In addition to recovery coaching services, AnB provides supportive services—such as housing referrals, employment readiness services, and medical services—in addition to therapy, treatment process groups, and other programming.

AnB worked with seven AmeriCorps VISTAs who supported the organization's project management, partnership efforts with other community and workforce development organizations, and training programs for staff. At the time of the study, AnB worked with a partner organization—Harmony, Hope, and Healing—to provide opioid recovery coaching services to their clients. AnB had five recovery coaches. Recovery coaches in Illinois are required to be certified by the state.

Foundation for Recovery

Established in 2005, Foundation for Recovery (FFR) has built programs and partnerships to remove barriers for Nevada families and communities affected by substance use and mental health disorders. FFR provides recovery support services to vulnerable populations—such as individuals in detention centers, jails, and emergency room departments—and in underserved areas with nonexistent or extremely limited services, such as rural and frontier communities spread throughout the state. Nevada's rural and frontier communities are spread over 87 percent of the state's landmass, with many far from health care centers, including addiction and mental health care services and providers. The average distance between acute care hospitals in rural Nevada and the next level of care of tertiary care hospital is 118.1 miles. To serve these communities, FFR dispatches staff to conduct mobile outreach in the state's most remote areas to deliver one-on-one recovery coaching (in-person and telephonically), training, recovery meetings, and social events in partnership with community-based organizations. To help clients meet their needs, FFR provides linkages to other services such as clothing, employment, and group support.

FFR has two pathways to receive services: (1) Care Connection is a program designed specifically to connect folks in recovery to needed resources without other in-house recovery programming and (2) RecoverU is a 12-week program incorporating Whole Health Action Management groups, coaching, and "electives" including volunteer work, art and music therapy, mutual aid groups, etc.

[8] From Above and Beyond's *Annual Report 2021: Annual Data Inventory and Learning Report*.

FFR worked with 16 AmeriCorps members who served as recovery coaches. These coaches were spread out at various locations including FFR's community center, libraries, and other community centers.

Healing Action Network

Healing Action Network (Healing Action) provides access to preventative mental health services through case management, opioid education therapeutic counseling, and community education to St. Louis, Mo., and surrounding areas. The organization's populations of focus are adult survivors of commercial sexual exploitation, which includes sex trafficking, prostitution, survival sex, escorting, stripping, and pornography. Most of Healing Action's clients have experienced complex, multilayered trauma and have one or more mental health diagnoses. Because of a lack of community awareness, adequate services, and access to basic needs, victims of sex trafficking are more likely to experience substance use disorders, mental health issues, and revictimization by pimps and traffickers. To best support Healing Action's clientele, the organization's recovery coaches have lived experience with substance use and trafficking, have at least 2 years of continuous sobriety prior to joining Healing Action, and are usually students coming out of master's programs rather than AmeriCorps volunteers. Recovery coaches provide one-on-one coaching and peer support groups. To help clients meet their needs, Healing Action also provides support services, such as gas cards and transportation, and connects their clients to food pantries, substance use treatment centers, homelessness services, and other resources.

Healing Action worked with 13 AmeriCorps volunteers who supported the organization's case management and provided therapy, technical assistance, and community education.

Recovery Corps

Recovery Corps works with organizations in Minnesota and Illinois that serve people in recovery for opioid use disorder and other substance-use disorders. Recovery Corps works with a variety organizations, including recovery residence associations, recovery community organizations, treatment facilities, collegiate recovery organizations, and recovery high schools. As many of these organizations do not have staff who can provide recovery coaching, Recovery Corps helps these organizations fill gaps and provide recovery coach services to more individuals. In addition to peer support and coaching, Recovery Corps helps clients navigate additional, external resources.

When selecting their 59 AmeriCorps members, Recovery Corps ensured the members came from the communities the organization serves and identified as people in long-term recovery for at least 1 year. AmeriCorps members at Recovery Corps served as recovery coaches and provided one-on-one recovery coaching services to clients. In addition, some other AmeriCorps members served as opioid response project coordinators. The organization defines a person served as someone who has met with a recovery coach three or more times, but some of the individuals the organization serves met with a recovery coach less than three times.

Appendix C. Survey Instruments

Project Director/Manager Survey

Survey Consent

Participation

Thank you for taking the time to participate in this survey. This survey is part of a study being conducted by ICF is to help AmeriCorps and [program name][9] better understand how their programs are working. More specifically, we are interested in your program's use of the recovery coach model, and how it affected your organization and the community you served. The survey will take about 15 minutes to complete.

Risks

We do not anticipate any risks in participating in this survey. Participation in this survey is voluntary. You can skip any question or stop answering questions at any time.

Your responses to the survey will be kept confidential. Your answers will not affect your current or future work with AmeriCorps. A report summarizing feedback across different recovery coaches, program participants, and organizations will be shared with AmeriCorps. Only ICF staff will see the data collected from this survey, and the information that we use from this survey will not be identified with any one individual.

Questions

Should you have any questions about the interview, you may contact study representative, Dr. Rosemarie O'Conner at Rosemarie.OConner@icf.com, or 703-251-0361. For questions regarding your rights related to this evaluation, you can contact ICF's Institutional Review Board at IRB@icf.com.

If you agree to participate in the survey, please acknowledge below by selecting, "I agree to participate."

- I agree to participate
- I do not agree to participate *[if selected, will use skip logic take respondent to the end of the survey]*

Survey Items

Management of recovery coaches

1. What is your current role at [organization name]?
   - Program assistant
   - Program manager
   - Director
   - Other (please specify): _____
2. Has your organization received funding or resources through the Federal Opioid Development grant? If yes, please specify: _____
3. How many recovery coaches does your program employ? _____
4. How many coaches are paid? _____
5. How many coaches are part-time?

[9] Throughout the Survey Instruments section, bracketed text indicates where site- or program-specific language would be inserted for respondents or where the online survey would skip sections based on respondent answers.

6. How many coaches are in recovery themselves?
7. Do you keep track of recovery coaches' relapses?
   - Yes
   - No
8. Does your program have a monitoring and oversight plan?
   - Yes
   - No *[If no, skip to question 11.]*
9. How many individuals with an opioid use disorder does your organization currently serve? _____
10. How many individuals with an opioid use disorder does your organization currently serve through recovery coaching? _____
11. Does your organization have a process to maintain contact with clients after they enter the program?
    - Yes
    - No
12. How does your organization recruit recovery coaches?
    - Internal recovery program/program graduates
    - Community recovery programs
    - Other community organizations
    - Schools and universities
    - Other (please specify): _____
13. How important is it for a potential recovery coach to possess lived experience?
    - Very important
    - Important
    - Neither important nor unimportant
    - Unimportant
    - Very unimportant
14. Our organization requires that recovery coaches are certified by the state of [State name].
    - Yes
    - No
    - Other (please specify): _____
15. Per week, how many hours are recovery coaches required to provide services? Please specify: _____
16. How important is it that AmeriCorps allows recovery coaches to have scheduling flexibility and serve [part-time or near full-time] so that they can attend to their own recovery needs?
    - Very important
    - Important
    - Neither important nor unimportant
    - Unimportant
    - Very unimportant
17. How important is it to your program that a volunteer does not relapse, in order to remain as a recovery coach?
    - Very important
    - Important
    - Neither important nor unimportant
    - Unimportant

- Very unimportant

Recovery coach training

18. Does your program have an onboarding process for recovery coaches, including supervision policies and required training?
    - Yes
    - No
    - Other (please specify): _____
19. Are recovery coaches at your organization required to complete a state or national certification before beginning employment?
    - Yes (please specify what state/national credentialing agency your organization uses): _____
    - No
20. Are you using any training curriculum for recovery coaches?
    - Yes (please specify): _____
    - No
21. What type of training curriculum are you using for recovery coaches at your organization?
    - National training curriculum
    - State training curriculum
    - Organizational training curriculum
    - We do not use a training curriculum
22. In which of the following areas does the program at [org name] offer employees or clients a culturally responsive treatment environment? (Select all that apply.)
    - Organizational values
    - Governance
    - Client treatment planning
    - Evaluation and monitoring
    - Language service
    - Workforce and staff development
    - Organizational infrastructure
    - Other (please specify):_____
23. The program at [organization name] assesses and incorporates the following components into a client's treatment. (Select all that apply.)
    - English, bilingual, or multilingual fluency
    - Racial, ethnic, and cultural identities
    - Family and extended family concerns (including nonblood kinships)
    - Trauma history
    - Relationship and dating concerns
    - Sexual and gender orientation
    - Health concerns
    - Beliefs about substance use, abuse, and dependence
    - Beliefs about substance abuse treatment
    - Family views on substance use and substance abuse treatment
    - Treatment concerns related to cultural differences
    - Cultural approaches to healing or treatment of substance use and mental disorders
    - Work history and concerns
    - Socio-economic and financial concerns
    - Current network of support

- Community concerns
- Other (please specify): _____

24. How is the training for recovery coaches offered? (Select all that apply.)
    - One-on-one
    - Group
    - Online
    - In person
25. How many hours of training are recovery coaches required to attend?
    - Less than 1 hour
    - 1-4 hours
    - 5-8 hours
    - 9-16 hours
    - 17+ hours
26. Does your organization provide opportunities for recovery coaches to connect with each other?
    - Yes
    - No

Recovery coach services

27. How often do recovery coaches interact with individuals diagnosed with opioid use disorder?
    - Daily
    - One day a week or more
    - One or two days a month
    - A couple of times per year
    - Less than two times per year
28. What other supports or services do you connect clients to? (Select all that apply.)
    - Food assistance
    - Transportation assistance
    - Emergency shelter
    - Physical or behavioral health providers
    - Other (please specify): _____
29. Please specify what community organizations your program works with to provide additional resources for clients with opioid use disorders and what services these organizations provide: _____
    - We do not work with community organizations
30. Please rate your level of agreement with each statement below. [answer options: strongly agree, agree, neither agree or disagree, disagree, and strongly disagree]
    - My program has the organizational capacity needed to provide services.
    - My program is able to leverage grant (i.e., financial) support.
    - My program is able to collaborate with partners, organizations, and community resources.
    - My program has received the support needed from AmeriCorps.
    - The criminal history background check is problematic.
    - The volunteer stipend is sufficient.
31. Do you have any other comments? _____

Recovery Coach Survey

Survey Consent

Participation

Thank you for taking the time to participate in this survey. This survey is part of a study being conducted by ICF to help AmeriCorps and [program name] better understand how their programs are working. More specifically, we are interested in your experience as a recovery coach. The survey will take about 15 minutes to complete.

Risks

We do not anticipate any risks in participating in this survey. Participation in this survey is voluntary. You can skip any question or stop answering questions at any time.

Your responses to the survey will be kept confidential. Your answers will not affect your current or future work with AmeriCorps or [program name]. A report summarizing feedback across different recovery coaches, program participants, and organizations will be shared with AmeriCorps. Only ICF staff will see the data collected from this survey, and the information that we use from this survey will not be identified with any one individual.

Questions

Should you have any questions about the interview, you may contact study representative, Dr. Rosemarie O'Conner at Rosemarie.OConner@icf.com, or 703-251-0361. For questions regarding your rights related to this evaluation, you can contact ICF's Institutional Review Board at IRB@icf.com.

If you agree to participate in the survey, please acknowledge below by selecting, "I agree to participate."

- I agree to participate
- I do not agree to participate *[if selected, will use skip logic take respondent to the end of the survey]*

Survey Items

Background

1. How long have you been with [participating organization name] as volunteer?
   - Less than 1 year
   - 1-5 years
   - 6-10 years
   - 11-15 years
   - 16+ years
2. How long have you worked as a volunteer?
   - Less than 1 year
   - 1-5 years
   - 6-10 years
   - 11-15 years
   - 16+ years
3. What is your work status at [participating organization name]?
   - Full-time

- Part-time

4. Why did you choose to become a recovery coach? (Select all that apply.)
   - Desire to help people seeking recovery from a substance use disorder
   - As an alternative to full-time paid employment
   - My own lived experience or recovery motivated me
   - To help my community
   - To learn new skills
   - I enjoy working with people
   - Other (please specify): _____
5. I am certified by the state of [State name] in recovery coaching.
   - Yes
   - No
   - Other (please specify): _____
6. I have made/I am interested in making/I plan to make a career out of recovery coaching.
   - Yes
   - No
   - Don't know

Training

7. How many hours of recovery coach training have you received?
   - Less than 1 hour
   - 1-4 hours
   - 5-8 hours
   - 9-16 hours
   - 17+ hours
8. Was the training you received in a group or one-on-one? (Select all that apply.)
   - One-on-one
   - Group
   - Online
   - In person
9. Did someone at your organization deliver the training, or was it delivered by someone outside of the organization?
   - The instructor was from the organization
   - The instructor was from outside the organization
   - Don't know
10. Did the training use a specific curriculum or manual?
    - Yes (please specify): _____
    - No
    - Don't know
11. Did you find the training helpful?
    - Yes
    - No

Services

12. On a weekly basis, how many clients do you work with as a recovery coach?
    - Less than 5 clients

- 5-10 clients
- 11-20 clients
- 21-30 clients
- 31+ clients

13. About how many hours per week do you work as recovery coach?
    - Less than 1 hour
    - 1-4 hours
    - 5-8 hours
    - 9-16 hours
    - 17+ hours
14. Do you work with the same clients each week, or does your organization rotate clients among coaches?
    - I work with the same clients each week.
    - My organization rotates clients among coaches.
    - Other (please specify): _____
15. How often do you see each of the clients you work with?
    - Daily
    - One day a week or more
    - One or two days a month
    - A couple of times per year
    - Less than two times per year
16. On average, how much time do you spend with each client per week?
    - Less than 1 hour
    - 1-4 hours
    - 5-8 hours
    - 9-16 hours
    - 17+ hours
17. What mode of interactions do you have with clients? (Select all that apply.)
    - In-person meetings
    - Check-in calls
    - Video calls (Zoom, Skype, FaceTime, etc.)
    - Text messages
    - Emails
    - Other (please specify): _____
18. Do you work with other coaches or medical personnel to help address the needs of clients with opioid use disorders?
    - Yes
    - No
    - Don't know
19. What services do you provide or facilitate as a recovery coach?
    - Individual sessions/case management
    - Group sessions
    - Service referrals
    - Other (please specify): _____
20. The treatment plans I develop with my clients reflect their culture and worldviews. (Select the response that best fits your answer.)
    - Completely

- Very well
- Somewhat
- Not very well
- Not at all

21. What other supports do you connect clients to?
    - Emergency shelters
    - Food services
    - Employment services
    - Physical or behavioral health providers
    - Other services (please specify):
    - I do not connect individuals to outside resources

Outcomes

22. How much do you agree or disagree that you get these benefits out of being a recovery coach? [answer options: strongly agree, agree, neither agree or disagree, disagree, and strongly disagree]
    - Satisfaction from helping individuals with opioid use disorders enter long-term recovery
    - Satisfaction from improving the health of my community
23. How satisfied are you with the following aspects of being a recovery coach? [answer options: very satisfied, satisfied, neither satisfied nor dissatisfied, dissatisfied, and very dissatisfied]
    - Training or access to training courses
    - Social events or opportunities for socializing
    - Support, management, and mentorship from my organization
    - Recognition for my contributions as a recovery coach
24. Please rate the following statements based on whether each factor has increased or decreased for you since becoming a recovery coach. [answer options: increased greatly, increased, stayed the same, decreased, and decreased greatly]
    - My knowledge of risk factors that lead to opioid addiction
    - My ability to help individuals with opioid addiction
    - My confidence, self-esteem, or self-management
    - Skills like teamwork, communication, leadership, or technical skills
    - My health, well-being, or fitness
    - My sense of community and belonging
    - My own ability to stay in recovery
25. Do you feel you have adequate support from [participating organization]?
    - Yes
    - No
    - Don't know
26. Are you currently in long-term recovery?
    - Yes
    - No
    - Prefer not to say

    If no, skip to question 30 about your experience as a volunteer.
27. Do you feel possessing lived experience affects relationship-building with your clients?
    - Yes
    - No

- Prefer not to say

28. Do you feel that being a recovery coach is transforming your own life?
    - Yes
    - No
    - Prefer not to say
29. In your recovery, did you ever have any recovery support?
    - Yes
    - No
    - Prefer not to say
30. How important is it that AmeriCorps allows you scheduling flexibility to serve [part-time or near full-time] so that you can attend to your own recovery needs?
    - Very important
    - Important
    - Neither important nor unimportant
    - Unimportant
    - Very unimportant

Experience as an AmeriCorps volunteer

31. Is this position with AmeriCorps your first professional job experience?
    - Yes
    - No
32. Do you plan to use the education award?
    - Yes
    - No
    - Don't know

    If no, skip to question 34.

33. How do you plan to use the education award?
    - To go to community college
    - To go to trade school
    - To go to a 4-year college
    - Other (please specify): _____
    - Don't know
34. Do you maintain contact with other coaches?
    - Yes
    - No

    If no, skip to question 36.

35. How useful is maintaining contact with other coaches?
    - Very useful
    - Useful
    - Not clear
    - Not very useful
36. Do you think this position will provide you with future job opportunities?
    - Yes
    - No

Demographics

37. What is your age?
    - 18-29
    - 30-39
    - 40-49
    - 50-59
    - 60-69
    - 70-79
    - 80+
38. How do you describe your gender? (Select all that apply.)
    - Male (including transgender men)
    - Female (including transgender women)
    - Non-binary/non-conforming
    - Prefer to self-describe as _____
    - Prefer not to say
39. Which one of these groups would you say best represents your race?
    - White
    - Black or African American
    - American Indian or Alaska Native
    - Asian or Pacific Islander
    - Other (please specify): _____
    - Don't know
    - Prefer not to say
40. Are you of Hispanic, Latino/a, or Spanish origin?
    - Yes
    - No
    - Don't know
    - Prefer not to say
41. What is the highest grade or year of school you completed?
    - Never attended school or only kindergarten
    - Elementary
    - Some high school
    - High school graduate or equivalent
    - Some college or technical school
    - College graduate
    - Prefer not to say
42. Do you have any other comments? _____

Program Participant/Comparison Group Survey

Survey Consent

Participation

Thank you for taking the time to participate in this survey. This survey is part of a study being conducted by ICF to help AmeriCorps and [program name] better understand how their programs are working. More specifically, we are interested in [program name]'s use of the recovery coach model, and how it affected you during your recovery. The survey will take about 10 minutes to complete.

Risks

We do not anticipate any risks in participating in this survey. Participation in this survey is voluntary. You can skip any question or stop answering questions at any time.

Your responses to the survey will be kept confidential. Your answers will not affect your current or future work with AmeriCorps or [program name]. A report summarizing feedback across different recovery coaches, program participants, and organizations will be shared with AmeriCorps. Only ICF staff will see the data collected from this survey, and the information that we use from this survey will not be identified with any one individual.

Questions

Should you have any questions about the interview, you may contact study representative, Dr. Rosemarie O'Conner at Rosemarie.OConner@icf.com, or 703-251-0361. For questions regarding your rights related to this evaluation, you can contact ICF's Institutional Review Board at IRB@icf.com.

If you agree to participate in the survey, please acknowledge below by selecting, "I agree to participate."

- I agree to participate
- I do not agree to participate *[if selected, will use skip logic take respondent to the end of the survey]*

Survey Items

(Questions marked with * are for program participants only.)

Experience with the recovery service

1. How long have you been receiving services from [organization name]?
    - Less than one month
    - 1-3 months
    - 4-6 months
    - 7-12 months
    - More than a year
2. What type of services do you receive from [organization name]? (Select all that apply.)
    - Recovery coaching
    - Naloxone training
    - Outpatient treatment
    - Inpatient treatment
    - Medication-assisted treatment
    - Group sessions

- Individual sessions
- Referrals to services with other organizations (e.g., food assistance, transportation assistance, emergency shelter, treatment services, etc.)
- Other (please specify): _____

3. Were you connected to outside services, such as housing assistance, health services, food assistance, etc. by [organization name]?
   - Yes
   - No
   - Not applicable

   [If no, skip to question 5.]
4. What kind of outside services were you referred to by [organization name]?
   - Emergency shelter
   - Food assistance
   - Physical addiction-related health services (e.g., detoxification, residential programs, medication assisted therapy, etc.)
   - Behavioral addiction-related health services (e.g., group counseling, individual counseling, 12-step programs, etc.)
   - Other health services
   - Other (please specify): _____
5. How often do you communicate or check in with your recovery coach?*
   - Multiple times each day
   - Once per day
   - One to four times per week
   - One or two times per month
   - A couple of times per year
   - Other (please specify): _____
6. About how many hours per week do you work with your recovery coach?*
   - Less than 1 hour
   - 1-4 hours
   - 5-8 hours
   - 9-16 hours
   - 17+ hours
   - Other (please specify): _____
7. How do you rate the quality of services you have received with [organization name]?
   - Excellent
   - Good
   - Fair
   - Poor
8. Please rate the quality of services your recovery coach provides from 1 to 5, with 1 being lowest quality and 5 being highest quality.*
   - 1
   - 2
   - 3
   - 4
   - 5
9. My treatment plan reflects my culture and worldview. (Select the response that best fits your answer.)

- Completely
- Very well
- Somewhat
- Not very well
- Not at all

10. How likely are you to recommend this program to another person who uses opioids?
    - Very likely
    - Likely
    - Not likely or unlikely
    - Unlikely
    - Very unlikely
11. Would you ever consider becoming a recovery coach?
    - Yes
    - No
    - Don't know
    - Prefer not to say

Outcomes

12. How often have you used opioids in the last 30 days?
    - One or more times per day
    - A few times per week
    - A few times per month
    - Once a month
    - I have not used opioids in the last 30 days
13. Since entering recovery, how often have you used physical and/or behavioral health services on average?
    - Daily
    - Once per week or more
    - One to two times per month
    - A couple of times per year
    - Less than two times per year
    - I do not attend health services
    - Other (please specify): _____
14. Please rate your level of agreement with each statement below. *[answer options: strongly disagree, disagree, neither agree or disagree, agree, and strongly agree]*
    - There are more important things to me in life than using substances.
    - In general, I am happy with my life.
    - I have enough energy to complete the tasks I set for myself.
    - I am proud of the community I live in and feel a part of it.
    - I get the support I need from friends.
    - I get the support I need from family.
    - I regard my life as challenging and fulfilling without the need for using drugs or alcohol.
    - My living space has helped drive my recovery journey.
    - Since entering recovery, I take full responsibility for my actions.
    - I am happy to deal with a range of professional people.
    - I am making progress on my recovery journey.

Demographics

15. What is your age?

- 17 or younger
- 18-29
- 30-39
- 40-49
- 50-59
- 60-69
- 70-79
- 80+

16. How do you describe your gender? (Select all that apply.)
    - Male (including transgender men)
    - Female (including transgender women)
    - Non-binary/non-conforming
    - Prefer to self-describe as _____
    - Prefer not to say
17. Which one of these groups would you say best represents your race?
    - White
    - Black or African American
    - American Indian or Alaska Native
    - Asian or Pacific Islander
    - Other (please specify): _____
    - Don't know
    - Prefer not to say
18. Are you of Hispanic, Latino/a, or Spanish origin?
    - Yes
    - No
    - Don't know
    - Prefer not to say
19. What is the highest grade or year of school you completed?
    - Never attended school or only kindergarten
    - Elementary
    - Some high school
    - High school graduate or equivalent
    - Some college or technical school
    - College graduate
    - Prefer not to say
20. Do you have any other comments? _____

Appendix D. Interview and Focus Group Protocols

Project Director/Manager Interview

Consent Form

Participation

Thank you again for taking the time to participate in today's interview. This interview is part of a study being conducted by ICF for AmeriCorps. The reason for the study is to help AmeriCorps and [program name] better understand how their programs are working. More specifically, we are interested in your program's use of the recovery coach model, and how it affected your organization and the community you served. We have prepared a number of discussion questions, but please feel free to offer any additional thoughts you have about your experience. The interview will take up to 90 minutes.

Risks

We do not anticipate any risks in being a part of this interview. Participation in today's discussion is completely up to you. You can decide you don't want to answer any question we ask you, and you can stop participating in the discussion at any time. You can also decide not to participate at all and leave the interview at any point.

Anything you share with ICF will be kept confidential. By speaking with us, you will not affect your current or future relationship with AmeriCorps. A report summarizing feedback across different recovery coaches, program participants, and organizations will be shared with AmeriCorps. Only ICF staff will see the data collected from this interview, and the information that we use from our discussions will not be identified with any one individual. However, since we are only talking to a small number of staff at each organization, there is a chance that AmeriCorps personnel will be able to guess which individual shared certain information.

Do you have any questions about this study or this interview?

Before we begin, we would also like to check that you are 18 years or older and to get your permission to participate in today's discussion. If you do not want to participate, you may leave at this time.

Consent Statement

1. You are 18 years or older.
2. You understand being a part of this study is completely up to you and that you can stop being a part of the discussion at any time, with no penalty or risk.
3. You understand that only ICF staff will see your answers to these questions.
4. You understand that your name will not be included in any reports or presentations of the results and that what you share with us today will be treated as confidential.
5. You understand the possible risks and benefits of being a part of this study.

Questions

Should you have any questions about the interview, you may contact study representative, Dr. Rosemarie O'Conner at Rosemarie.OConner@icf.com, or 703-251-0361. For questions regarding your rights related to this evaluation, you can contact ICF's Institutional Review Board at IRB@icf.com.

Interview Protocol

1. Let's begin with some brief introductions. Please tell me a little bit about yourself, including your name and your role in the program.
2. Can you tell me a little about the history of [organization name][10]?
3. Has your organization received funding through the Federal Opioid Development grant? If yes, please indicate the amount.
   Yes. Amount: $_____
   No.
4. Can you please share how you came to work with [organization name] and how long you have been with the program?
5. We recognize there are different names for the recovery coaching model. Do you characterize the model used at your organization as recovery coaching? If not, how would you describe it?
   (Probe, if not a recovery coach model):[11] How does your model differ from the recovery coach model?

The following questions pertain to the impacts of the COVID-19 pandemic on program operations.

6. In what ways are you adapting program activities and services to respond to the pandemic?
7. Was the training of recovery coaches adapted? If so, how?
8. How many coaches did you train? *(Probe, how do the numbers differ from pre-pandemic?)*
9. How have partner relationships changed? (Probe, is there any strain?)
10. How are you recruiting clients, access to people who needed help (for example, those identified through hospitals or the justice system)? How has this changed since the pandemic began, and what extra precautions are you taking?
    a. Were you able to reach the people who needed help (hospitals filled with response to the pandemic)?
    b. What happened to the people that weren't able to be supported?
11. How many individuals did you serve? *(Probe, how do the numbers differ from pre-pandemic?)*
12. What adaptations will you retain moving forward? Why?

As you think about answers to these next questions, we realize that things may be different as a result of the COVID-19 pandemic. Please tell us typically how you would typically implement your program and if so, how COVID has impacted the program since it began.

13. Can you please tell me about your organization's [recovery coach model] recruitment process?
14. What is your vetting process for [recovery coaches]? Does your program require [recovery coaches] to be at a certain level in their recovery in order to serve as a [recovery coach]?
15. Can you talk about the importance your organization places on the [recovery coach] having lived experience?
16. What level of qualification (e.g., required state, national certifications) do you expect from [recovery coaches]?
17. Describe how you ensure that your program is culturally appropriate for:
    Recovery coaches
    Clients
    (Probe: Curriculum? Training? Monitoring and assessment? Staffing? Treatment?)

[10] Throughout the Interview and Focus Group Protocols section, bracketed text indicates where site- or program-specific language would be inserted for respondents.
[11] Throughout the Interview and Focus Group Protocols section, parenthetical text indicates notes for the interviewer.

18. Can you please tell me about your program's process for [recovery coach] onboarding, including training and supervision?

    (Probe): How often are [recovery coaches] trained? Do you use a specific curriculum in the training?
19. Can you please tell me about the process for monitoring and oversight, including the data you collect, your data systems, and how you use this information in program decisions?
20. Can you describe what process your organization uses to maintain contact with service recipients after the initial intervention in your program?
21. How does your organization support [recovery coach model]?
22. For the coaches you employ who are in recovery, [if the org does not employ coaches in recovery, skip], does your organization keep track of coach relapses? (Skip this question if the organization does not employ coaches in recovery.)
23. What is the process when a recovery coach relapses? Is that coach allowed to continue working?
24. Do recovery coaches take advantage of AmeriCorps scheduling flexibility to serve part-time or near full-time so that they can attend to their own recovery needs?
25. To what extent do you work with other organizations or medical personnel to help address the needs of clients with opioid use disorders?
26. What other supports do you connect clients to beyond helping them address their opioid use disorder? Other supports may include emergency shelter services, food services, physical or behavioral health providers, or other services.
27. Do you provide opportunities for volunteers to connect with each other? If yes, how? If no, why not?
28. Does your program work with community partners? If so, can you please share what type of collaboration your organization has with these partners?
29. What are the most important skills for a [recovery coach] to have?
30. What is most important to address in [recovery coaching] with clients who have opioid use disorders?
31. What aspects of the program are most effective and what could be improved?
32. What types of support has your program received from AmeriCorps? What support was effective and what could be improved?
33. Other than the AmeriCorps benefits, does your organization provide any pay or incentive to your [recovery coaches]?
34. What are the challenges that the volunteers and your program experience related to AmeriCorps's criminal history background check requirements?
35. In what ways does the [recovery coaching model] improve beneficiary outcomes?

    (Probe for recovery capital, attendance of services, decrease in opioid use.)
36. In what ways does the [recovery coaching model] improve volunteer outcomes?

    (Probe for knowledge, attitude, and behavior.)
37. In what ways has the support from AmeriCorps to conduct the [recovery coaching model] improved your organization's capacity?
38. What are the best practices of engaging [recovery coaches]? What are the challenges?
39. Was your organization able to leverage other resources to support your [recovery coaching] program? If so, from what sources? How much?
40. Do you have any additional feedback or insights you would like to share with us regarding the program?

Partner Interview

Consent Form

Participation

Thank you for taking the time to participate in today's interview. This interview is part of a study being conducted by ICF to help AmeriCorps and [program name] better understand how their programs are working. More specifically, we are interested in your organization's partnership with [participating organization name] in providing recovery coach. We have prepared a number of discussion questions, but please feel free to offer any additional thoughts you have about your experience. The interview will take up to 30 minutes.

Risks

We do not anticipate any risks in being a part of this interview. Participation in today's discussion is voluntary. You can decide you don't want to answer any question we ask you, and you can stop participating in the discussion at any time. You can also decide not to participate at all and leave the interview at any point.

Anything you share with ICF will be kept confidential. By speaking with us, you will not affect your current or future relationship with AmeriCorps. A report summarizing feedback across different recovery coaches, program participants, and organizations will be shared with AmeriCorps. Only ICF staff will see the data collected from this interview, and the information that we use from our discussions will not be identified with any one individual.

Before we begin, we would also like to check that you are 18 years or older and to get your permission to participate in today's discussion. If you do not want to participate, you may leave at this time.

Questions

Should you have any questions about the interview, you may contact study representative, Dr. Rosemarie O'Conner at Rosemarie.OConner@icf.com, or 703-251-0361. For questions regarding your rights related to this evaluation, you can contact ICF's Institutional Review Board at IRB@icf.com.

Interview Protocol

1. Let's begin with some brief introductions. Please tell me a little bit about yourself, including your name, your role, and your organization.
2. Can you please share how you came to work with [participating organization name] and how long you have been partnering with [participating organization name]?
3. Can you tell me what services you provide for [participating organization name]?
4. To what extent are you familiar with the [recovery coach model] that [participating organization name] is using?
5. How regularly do you and [participating organization name] communicate about your shared clients?
6. Have you noticed a change in the individuals who have been working with [org name] in its [recovery coaching] program? *(Depending on the organization.)*

   (Probe for recovery capital, increase in health and attendance of health services, and decrease in opioid use.)
7. What aspects of the partnership are most effective?
8. What aspects of the partnership need to be improved?
9. What are the best practices in engaging with community partners? What are the challenges?
10. Do you have any additional feedback or insights you'd like to share with us regarding the program/partnership?

Recovery Coach Interview

Consent Form

Participation

Thank you again for taking the time to participate in today's interview. This interview is part of a study being conducted by ICF for AmeriCorps. The reason for the study is to help AmeriCorps and [program name] better understand how their programs are working. More specifically, we are interested in your program's use of the recovery coach model, and how it affected your organization and the community you served. We have prepared a number of discussion questions, but please feel free to offer any additional thoughts you have about your experience. The interview will take up to 60 minutes.

Risks

We do not anticipate any risks in being a part of this interview. Participation in today's discussion is completely up to you. You can decide you don't want to answer any question we ask you, and you can stop participating in the discussion at any time. You can also decide not to participate at all and leave the interview at any point.

Anything you share with ICF will be kept confidential. By speaking with us, you will not affect your current or future relationship with AmeriCorps or [program name]. A report summarizing feedback across different recovery coaches, program participants, and organizations will be shared with AmeriCorps. Only ICF staff will see the data collected from this interview, and the information that we use from our discussions will not be identified with any one individual. However, since we are only talking to a small number of recovery coaches at each organization, there is a chance that AmeriCorps or [program name] personnel will be able to guess which individual shared certain information.

Do you have any questions about this study or this interview?

Before we begin, we would also like to check that you are 18 years or older and to get your permission to participate in today's discussion. If you do not want to participate, you may leave at this time.

Consent Statement

1. You are 18 years or older.
2. You understand being a part of this study is completely up to you and that you can stop being a part of the discussion at any time, with no penalty or risk.
3. You understand that only ICF staff will see your answers to these questions.
4. You understand that your name will not be included in any reports or presentations of the results and that what you share with us today will be treated as confidential.
5. You understand the possible risks and benefits of being a part of this study.

Questions

Should you have any questions about the interview, you may contact study representative, Dr. Rosemarie O'Conner at Rosemarie.OConner@icf.com, or 703-251-0361. For questions regarding your rights related to this evaluation, you can contact ICF's Institutional Review Board at IRB@icf.com.

Interview Protocol

1. Let's begin with some brief introductions. Please tell me a little bit about yourself, including your name and role in the program.
2. We recognize there are different names for the recovery coaching model. Do you characterize the model used at your organization as recovery coaching? If not, how would you describe it?

   (Probe, if not a recovery coach model): How does the model at your organization differ from the recovery coach model?
3. Are you currently in recovery?

   (If yes, continue.)

   (If no, skip to question 6.)
4. In your recovery, did you receive any recovery support?
5. How does your own recovery or lived experience affect your work (e.g., relationship-building with your clients) as a [recovery coach]?
6. Can you please share the reasons you decided to become a coach with [organization name] and how long you have been with the program?
7. Did you receive any recovery training when you started at [organization name]?

   (If yes): How did you like the training? What aspects of the training could be improved?

   (If no): How did the [org name] familiarize you with your position?
8. Describe your work as a [recovery coach]. What does your daily schedule look like?

The following questions pertain to the impacts of the COVID-19 pandemic on program operations.

9. How has the pandemic impacted the work you are able to do? (Probe for changes in service delivery, numbers served)
10. If you have gone through a similar recovery coach program, how has this been different? (Probe for their own lived experience/recovery)
11. Given that the recovery programs weren't created to be delivered during a pandemic, what changes or adaptations to the program have been challenging?
    a. Would you recommend keeping any changes? Why?
12. Do you feel like you are able to reach the people who needed help? (Probe for perceived impacts)
    a. What happened to the people that weren't able to be supported?

As you think about answers to these next questions, we realize that things may be different as a result of the COVID-19 pandemic. Please tell us typically how you would typically work with clients in the program and if so, how COVID has impacted you providing treatment since it began.

13. How many individuals do you work with as a [recovery coach] in a week? Do you focus on the same individuals, or do clients rotate among coaches?
14. How many people are in your entire caseload? Do you feel like you can provide the support your clients need?
15. Describe how [org name] prepared or trained you to address culture and worldview in a client's treatment plan.
16. Describe how you incorporate your client's culture and worldview into the individual's treatment plan.
17. What do you do to help the individuals you work with combat opioid use disorder?

18. To what extent do you work with other coaches or medical personnel to help address the needs of individuals with opioid use disorder?
19. What other supports do you connect individuals to beyond helping them to address their opioid use disorder? Other supports may include emergency shelter services, food services, physical or behavioral health providers, or other services.
20. How effective do you think the [recovery coach model] is at helping individuals with opioid use disorders achieve sustained recovery? Do you believe that your work helps reduce overdose rates and recurrence of use?

    (Probe, if considered effective): What in your view makes the [recovery coach model] effective?

    (Probe, if not considered effective): What in your view does not make the [recovery coach model] effective?
21. In what ways has being a [recovery coach] changed your own life?

    (Probe for knowledge, attitude, and behavior.)
22. What do you like about being a [recovery coach]?
23. What is the biggest barrier you face in your day-to-day as a [recovery coach]?
24. Do you feel you receive the support needed from [organization name] to provide the care your clients need in their recovery journeys? What support has been effective and what could be improved?
25. Do you maintain contact with other coaches? If so, how useful is that?
26. Do you feel you receive the support needed from AmeriCorps to provide the care your clients need in their recovery journeys? What support has been effective and what could be improved?
27. Do you have plans to use the education award? If so, how do you plan to use it?
28. Would you say that the AmeriCorps position at [organization name] is your first professional job experience?
29. Do you think this position will provide you with future job opportunities? If so, how?
30. Do you have any additional feedback or insights you would like to share with us regarding the program?

Program Participant Focus Group

Consent Form

Participation

Thank you again for taking the time to participate in today's focus group. This focus group is part of a study being conducted by ICF for AmeriCorps. The reason for the study is to help AmeriCorps and [program name] to better understand how their programs are working. More specifically, we are interested in [program name]'s use of the recovery coach model, and how it affected you during your recovery. We have prepared a number of discussion questions, but please feel free to offer any additional thoughts you have about your experience. The focus group will take up to 60 minutes.

Risks

We do not anticipate any risks in being a part of this focus group. Participation in today's discussion is completely up to you. You can decide you don't want to answer any question we ask you, and you can stop participating in the discussion at any time. You can also decide not to participate at all and leave the focus group at any point.

Anything you share with ICF will be kept confidential. By speaking with us, you will not affect your current or future relationship with [program name]. A report summarizing feedback across different recovery coaches, program participants, and organizations will be shared with AmeriCorps. Only ICF staff will see the data collected from this focus group, and the information that we use from our discussions will not be identified with any one individual. However, since we are only talking to a small number of program participants at each organization, there is a chance that AmeriCorps or [program name] personnel will be able to guess which individual shared certain information.

We also request that you do not discuss what is disclosed in this focus group once the discussion ends.

Do you have any questions about this study or this focus group?

Before we begin, we would also like to check that you are 18 years or older and to get your permission to participate in today's discussion. If you do not want to participate, you may leave at this time.

Consent Statement

1. You are 18 years or older.
2. You understand being a part of this study is completely up to you and that you can stop being a part of the discussion at any time, with no penalty or risk.
3. You understand that only ICF staff will see your answers to these questions.
4. You understand that your name will not be included in any reports or presentations of the results and that what you share with us today will be treated as confidential.
5. You understand the possible risks and benefits of being a part of this study.
6. You understand that you are being asked to not discuss what is said in the focus group once the discussion ends.

Questions

Should you have any questions about the interview, you may contact study representative, Dr. Rosemarie O'Conner at Rosemarie.OConner@icf.com, or 703-251-0361. For questions regarding your rights related to this evaluation, you can contact ICF's Institutional Review Board at IRB@icf.com.

Focus Group Protocol

1. Let's begin with some brief introductions. Please tell me a little bit about yourself.
2. If you are comfortable sharing, can you please tell us how you became involved with [organization name] and how long you have been with the program?
3. Please describe what it's like working with a [recovery coach]. What kind of support do you receive from your [recovery coach]?
4. How frequently do you communicate with your [recovery coach]? Do you reach out to your coach, or does the coach normally initiate communication?
5. Have you worked with the same [recovery coach] since you have been with [organization name]?
6. How has COVID impacted you seeking treatment?
7. How effective has the [recovery coach model] been on your path to achieve sustained recovery?

   (Probe, if considered effective): What in your view makes the [recovery coach model] effective?

   (Probe, if not considered effective): What in your view makes the [recovery coach model] ineffective?
8. In what ways could your interactions with [recovery coaches] be improved?
9. What are the most important skills for a [recovery coach] to have?
10. Describe how your [recovery coach] incorporates your culture and worldview into your treatment plan?
11. What are the most important aspects of your recovery from opioid use disorder that you hope to address with your [recovery coach]?
12. How important is it to hear about your [recovery coach]'s lived experience and recovery when problem-solving or discussing your own recovery? How often is this brought up?
13. Did your [recovery coach] or [organization name] connect you with outside resources, such as emergency shelter services, food services, physical or behavioral health providers, or other services?
14. Do you attend health services, including physical or behavioral services, outside of your interactions with [organization name]?
15. Would you say that you attend more or fewer services than when you started working with [organization name]?
16. Does working with a [recovery coach] help you reduce your substance use including opioid use? If so, how?
17. How has your quality of life changed since beginning your work with a [recovery coach]?
18. If you saw someone who was struggling in recovery, would you recommend this program to that person?
19. Would you ever consider becoming a [recovery coach] yourself? Why or why not?
20. Do you have any additional feedback or insights you would like to share with us regarding the program?

Appendix E. State Certification Requirements

Certification	Minimum Education Required	Personal Recovery Required	Exam Required	Hours of Training/ Education	Hours of Work Experience	Hours of Supervised Practical Experience
Illinois[1]						
Certified Peer Recovery Specialist (CPRS)	High school diploma or GED	Yes 2 years	Successful score on the International Certification & Reciprocity Consortium (IC&RC) Peer Recovery Exam	100 clock hours	2,000 hours (1 Year)	100 clock hours of supervision
Certified Recovery Support Specialist (CRSS)	High school diploma or GED	Yes 2 years	Successful score on the CRSS Written Exam	100 clock hours	2,000 hours of supervised work experience (1 Year)	100 clock hours of supervision
Minnesota[2]						
Certified Peer Recovery Specialist (entry level)	High school diploma or GED	No	Passing score on IC&RC Peer Recovery Exam	46 clock hours	N/A	N/A
Certified Peer Recovery Specialist Reciprocal (advanced)	High school diploma or GED	No	Passing score on IC&RC Peer Recovery Exam	46 clock hours	500 hours of work experience	25 clock hours of supervision
Missouri[3]						
Certified Peer Specialist (CPS)	High school diploma or GED	Yes	Passing score on the CPS Online Exam	35 clock hours (weeklong 5-day training course)	N/A	N/A

Certification	Minimum Education Required	Personal Recovery Required	Exam Required	Hours of Training/ Education	Hours of Work Experience	Hours of Supervised Practical Experience
Certified Reciprocal Peer Recovery (CRPR)	High school diploma or GED	No	Passing score on IC&RC Peer Recovery Exam	100 clock hours	2,000 hours of applicable work/volunteer experience within the last 10 years	25 hours of peer supervision in the IC&RC peer recovery domains
Nevada[4]						
Peer Recovery Support Specialist (PRSS)	High school diploma or GED	Yes 2 years	Passing score on IC&RC Peer Recovery Exam	46 clock hours	475 hours of volunteer or paid work experience in one or more of the IC&RC peer recovery domains	25 hours of supervised experience with a minimum of 5 hours in each IC&RC peer recovery domain

[1] Illinois Certification Board professional certifications web page

[2] Minnesota Certification Board peer recovery credentials web page

[3] Missouri Credentialing Board credentials web page

[4] Nevada Certification Board Peer Recovery Support Specialist web page

About AmeriCorps

AmeriCorps, the federal agency for national service and volunteerism, provides opportunities for Americans to serve their country domestically, address the nation's most pressing challenges, improve lives and communities, and strengthen civic engagement. Each year, the agency places more than 200,000 AmeriCorps members and AmeriCorps Seniors volunteers in intensive service roles and empowers millions more to serve as long-term, short-term, or one-time volunteers. Learn more at AmeriCorps.gov.

About the Office of Research and Evaluation

The AmeriCorps Office of Research and Evaluation assists AmeriCorps and its partners in collecting, analyzing, and disseminating data and insights about AmeriCorps programs and civic life in America.

About ICF

ICF (NASDAQ:ICFI) is a global consulting and digital services company with over 9,000 full- and part-time employees, but we are not your typical consultants. At ICF, business analysts and policy specialists work together with digital strategists, data scientists and creatives. We combine unmatched industry expertise with cutting-edge engagement capabilities to help organizations solve their most complex challenges. Since 1969, public and private sector clients have worked with ICF to navigate change and shape the future. Learn more at icf.com.

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