An Evaluation of AmeriCorps-Supported Recovery Coach Programs

Fiscal Years 2020–2022

BUNDLED EVALUATION AND CAPACITY BUILDING PROJECT

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Prepared by ICF for the AmeriCorps Office of Research and Evaluation

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Executive Summary

This report details an evaluation of recovery coaching services across 11 AmeriCorps-supported organizations serving individuals with substance use disorders (SUDs). **Key findings and significance** from study surveys, interviews, and focus groups with project directors, recovery coaches, and program participants (i.e., those receiving recovery coaching services) include:

- AmeriCorps-supported organizations implemented recovery coaching services across diverse geographical regions and for diverse and challenging-to-treat target populations.
- Organizations leveraged paid staff, AmeriCorps State and National members, and VISTAs to provide direct services and/or contribute to other organizational activities.
- Programs use a **holistic ("whole person") and culturally appropriate approach** to services to recognize clients as individuals, which may increase treatment effectiveness.
- Recovery coaches' **lived experience** with SUD was generally believed to be important for building rapport and increasing client engagement, which can improve treatment outcomes. However, organizations varied in their definitions of, and requirements for, lived experience among their coaches.
- Hiring practices that disqualify candidates based on criminal history may impede otherwise qualified coaches from being hired.
- **Spending more time (9-16 hours/week) with a recovery coach** was associated with a large (1-point) increase in average recovery capital scores (range: 1–5) compared to those who spent less than 1 hour/week, adding evidence to suggest time spent with a recovery coach may be important for recovery capital outcome.
- Participants of Evaluation Capacity Building sessions self-reported the highest satisfaction rating for a session on "Feedback on the Bundled Evaluation," suggesting evaluation participation may be meaningfully enriched when **evaluation findings are shared with participants**, and opportunities for learning and discussion are provided.

This section summarizes the study background, research questions, methods, findings, discussion, and lessons learned.

Background

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 mitigation of SUD prevalence and related mortality rates is a public health emergency in the United States. In 2018, President Trump signed the SUPPORT for Patients and Communities Act to address the widespread overprescribing and abuse of opioids, and President Biden has subsequently declared the administration's commitment to addressing addiction and the overdose epidemic (The White House, 2022). The efforts of federal agencies such as AmeriCorps are critical to successfully undertake this national priority. AmeriCorps increased its efforts to fund programs specifically targeting opioid addiction and other SUDs. One promising strategy in substance use treatment to address the rising rates of SUDs and drug overdose is the approach of recovery coaching.

Recovery Coaching

Recovery coaching is the process in which a nonclinical professional typically 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).

The primary purpose of the work of recovery coaches is to function in a support role and to 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. These supports help individuals progress toward building the resources required to begin and maintain recovery, also known as recovery capital (Substance Abuse and Mental Health Services Administration [SAMHSA], 2017). Literature on recovery coaching has demonstrated a positive effect of recovery coaching interventions on outcomes such as substance use, housing stability, justice-involved status, mental and physical health, and uptake of services related to recovery from an SUD (Bassuk et al., 2016; Eddie et al., 2019).

Knowledge Gaps and the Current Study

The evaluation of recovery coaching as a substance use treatment strategy is still in nascent phases and more knowledge is needed on its implementation and associated outcomes. A foundational report on the use of AmeriCorps funding to support recovery coaching programs contributed important insights into the organizational makeup and administration of 16 programs across the United States (Zandniapour et al., 2020). The current study aims to build upon the evidence base surrounding recovery coaching programs by detailing the services provided and the outcomes of program participants, recovery coaches, and organizations across AmeriCorps-supported organizations implementing a recovery coaching approach (regardless of whether the recovery coaching services are provided by AmeriCorps State and National members, VISTAS, or organizations' staff). In 2020, AmeriCorps contracted with an independent consulting firm, ICF, to provide a comprehensive evaluation of AmeriCorps projects' use of recovery coaching models and deliver targeted Evaluation Capacity Building services to AmeriCorps-supported organizations participating in the evaluation.

A wide range of terms is used to refer to the role of a recovery coach in the substance use space, for example "peer support specialists" and "navigators." The term "peer" often refers to a recovery coach who has some degree of shared experience with an SUD and/or recovery.

Research Questions and Methods

This evaluation collects and analyzes data from and about AmeriCorps-supported organizations with recovery coaching services to address 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. The specific implementation and outcome research questions that comprise the overarching objectives are summarized in exhibit ES-1.

EXHIBIT ES-1.—Research questions guiding this evaluation

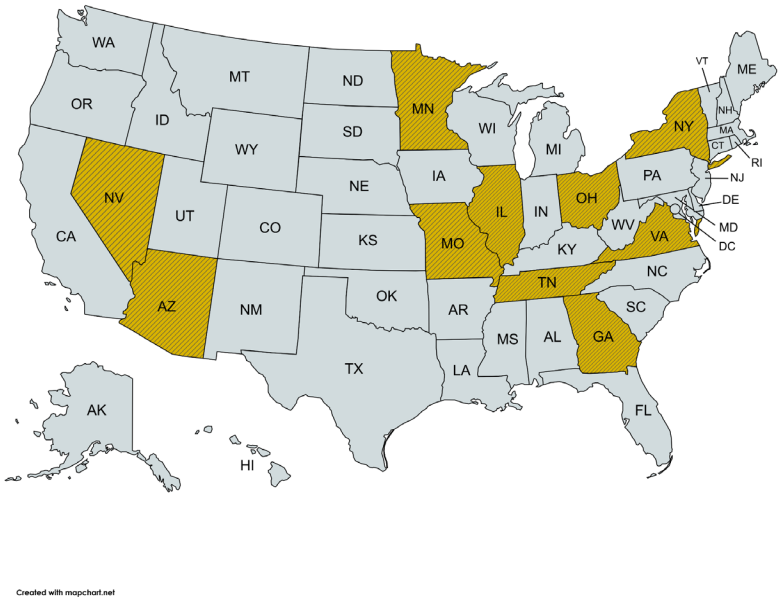
Implementation Questions	Outcome Questions
• How do organizations recruit and work with recovery coaches to provide the service? • How do organizations work with partners to help program participants fill in the gaps of their holistic treatment plans? • What kinds of support do organizations provide 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?	• 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 report improved knowledge, attitudes, and behaviors? • To what extent do program participants improve their recovery capital when participating in recovery coaching? • To what extent do program participants increase attendance to physical and behavioral health services when participating in recovery coaching? • To what extent do program participants experience a decrease in substance use when participating in recovery coaching?

Methods

This study's data collection and reporting processes resulted in two "cohorts" of participating organizations. Recruitment and data collection began for AmeriCorps-supported organizations with fiscal year (FY) 2020 projects, which resulted in a small sample of four participating organizations and survey data for N = 6 project directors or program partners, N = 41 recovery coaches, N = 22 program participants, N = 18 comparison individuals, and N = 1 AmeriCorps member. Interview or focus group data were gathered for N = 8 project directors or program partners, N = 5 recovery coaches, N = 12 program participants, and N = 4 AmeriCorps members. The evaluation launched another data collection endeavor with a second cohort ("Cohort 2") to increase the final evaluation's sample size with organizations with FY 2021 and 2022 projects. This second cohort resulted in additional survey data for N = 15 project directors, N = 33 recovery coaches, N = 61 program participants, N = 2 comparison individuals, and N = 27 AmeriCorps members. Interview or focus group data were gathered for N = 38 project directors or program partners, N = 42 recovery coaches, N = 67 program participants, and N = 27 AmeriCorps members. The final, combined sample sizes across respondent group types are shown in exhibit ES-3.

In total, 17 project applications from FY 2020 and 34 project applications from FY 2021 and FY 2022 for AmeriCorps State and National and AmeriCorps VISTA projects were reviewed for use of a recovery coaching model as well as organizations' unique structures, approaches, and populations served. Initially, 17 qualifying organizations agreed to participate, but 6 organizations withdrew from the study in the months that followed. Some cited concerns about client confidentiality while others simply withdrew without explanation. The final sample included 11 organizations—7 AmeriCorps State and National grantees and 4 AmeriCorps VISTA sponsors—located in New York, Georgia, Tennessee, Virginia, Ohio, Illinois, Minnesota, Missouri, Arizona, and Nevada (see exhibit ES-2 for map highlighting states with participating programs). Four organizations had FY 2020 projects, four had FY 2021 projects, two had FY 2022 projects, and one organization (RHOPE) had both FY 2021 and 2022 projects. Each organization is detailed in the Recovery Coaching Programs chapter.

EXHIBIT ES-2.—Map showing states with participating organizations



This evaluation used an ICF Institutional Review Board-approved mixed-methods approach, which included a review of program documents (e.g., AmeriCorps project applications), surveys, and focus groups/interviews. Study surveys, focus groups, and interviews were conducted with participants who read and agreed to the study consent forms (see Appendices A and B).

Online and paper-based surveys were collected between November 2021 and January 2024 for project directors/managers, recovery coaches, program participants (i.e., beneficiaries of recovery coaching), and comparisons (i.e., those who are receiving SUD treatment but not recovery coaching):

- **Project director/manager surveys** assessed organizational capacity, staff recruitment, ability to leverage grant financial support, and collaboration with partners and community resources.
- **Recovery coach surveys** assessed knowledge, attitudes, and behaviors; activities and services provided; experiences with the organizations; and experiences with program participants.
- **Program participant and comparison group surveys** assessed recovery capital, attendance to physical and behavioral health services, incidence of substance use, and experiences interacting with organizations and recovery coaches.

In anticipation of difficulty recruiting from this subpopulation, $25 Amazon gift cards were given to comparison group respondents. The same incentivization was expanded to coaches and program participants in later stages of the evaluation to increase participation rates.

Demographic characteristics of the survey sample are detailed in the Methods and Data Sources chapter. Briefly, over half of recovery coaches (57 percent) were female and were White (57 percent), and most were non-Hispanic (85 percent). Of the program participants, there was a relatively similar prevalence between male (48 percent) and female (36 percent) participants. More than 55 percent were White and 20 percent

were Black or African American. Sixty-four percent identified as non-Hispanic, Spanish, or Latino/a, and the majority (85 percent) had a high school diploma or higher educational attainment.

Virtual and in-person site visits were conducted between May 2022 and December 2023, and included:

- 60-minute interviews with organization project directors
- 60-minute interviews and/or focus groups with recovery coaches
- 30-minute interviews with partner organizations and AmeriCorps members
- 60-minute focus groups with program participants

Thirty-minute individual interviews were also conducted with program participants due to difficulty recruiting this respondent group for 60-minute sessions. Program participants and recovery coaches were given $25 Amazon gift cards as an incentive to increase participation rates. Exhibit ES-3 summarizes the number of survey and focus group/interview participants for each participant group.

EXHIBIT ES-3.—Number of participants across surveys and focus groups/interviews completed for each participant group

Participant Group	Surveys	Focus Groups/Interviews
Project Directors	20	35
Recovery Coaches	72	47
AmeriCorps Members or VISTAs	28	25
Program Partner	-	11
Program Participant	83	70
Comparison	20	-
Total	**231**	**188**

Due to organizations' general preference not to share contact information for potential participants, the majority of surveys were distributed by the organization in a way that forbade the calculation of response rates.

Analysis

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. In the absence of a sufficient sample size for a comparison group, the program participants' data were analyzed as a series of regression models, detailed further in the Program Outcomes chapter.

Interviews and focus groups were audio-recorded and transcribed for analysis. The transcripts were analyzed based on a codebook the study team developed. All qualitative data were indexed and coded for descriptive and thematic analyses using NVivo or Dedoose 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. Quotes emblematic of findings trends and sentiments were also identified and are shared throughout the findings sections of this report.

Recovery Coaching Programs Implementation Findings

All 11 programs included in this evaluation treat individuals with SUDs and use a recovery coaching support model. To varying extents, recovery programming includes emphases on lived experience, cultural competence, holistic care, and harm-reduction practices—each of these programmatic elements are discussed further in the findings sections. The organizations varied in the geographic regions and populations they served, the role of AmeriCorps State and National members/VISTAs, the terminology used for those performing the services of a recovery coach, and the applicability of lived experience for recovery coaches. Exhibit ES-4 summarizes each organization.

EXHIBIT ES-4.—Overview of participating organizations

Organization & Project Type	Project Mission and Target Population	Role of AmeriCorps State and National Members/VISTAs	Lived Experience of Recovery Coaches*
Above and Beyond Family Recovery Center (AnB) **AmeriCorps VISTA**	**Mission**: 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. **Focus Population:** Based in Illinois, AnB serves clients from Chicago and neighboring suburbs, with most clients coming from Chicago's West Side. AnB's populations 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).	VISTAs support project management and capacity-building services related to housing and employment, community outreach, and education. Staff provided recovery coaching services.	Lived experience required: Yes Recovery coaches all have firsthand lived experience with an SUD. Recovery coaches are called "certified recovery support specialists" and are paid staff.
Align9 **AmeriCorps VISTA**	**Mission:** Align9 is an onramp to coordinated services through a faith-based 12-step recovery program. Services are offered at local churches, including housing, legal, Certified Peer Specialist (CPS), food, and employment services. **Focus Population:** Align9 serves individuals who have had or are currently suffering from substance use disorder (SUD). The organization is focused on meeting local community needs related to the devastating effects of the opioid epidemic in the Counties of Roane, Loudon, Morgan, and Meigs in Tennessee.	VISTAs support Align9 by supporting recovery coach development, coordinating social media communications, and assisting with health programming. Staff provided recovery coaching services.	Lived experience required: No Recovery coaches are not required to have firsthand lived experience with an SUD. Many coaches identified as being in recovery in a broad sense: "We are all in recovery from something." Recovery coaches are called "peer recovery coaches."

Organization & Project Type	Project Mission and Target Population	Role of AmeriCorps State and National Members/VISTAs	Lived Experience of Recovery Coaches*
County of Washington **AmeriCorps State and National**	**Mission:** The County of Washington provides recovery coaching and develops recovery infrastructure, including recovery housing, transitional housing, evidence-based self-management programs, and community improvement projects. The initial focus is on wellness activities and sustained recovery from addiction. **Focus Population:** The organization serves individuals in western West Virginia and eastern Ohio who have had or are currently suffering from chronic illness.	AmeriCorps members serve as peer support workers providing recovery coaching services and other connections to resources to program participants.	Lived experience required: Yes Recovery coaches are required to have firsthand lived experience with an SUD and/or a mental illness and are called "peer recovery support workers."
Covenant Community **AmeriCorps VISTA**	**Mission:** Covenant Community hosts a residential intensive treatment program that uses a therapeutic community model to assist its residents in overcoming their SUDs. **Focus Population:** The organization serves men experiencing homelessness and recovering from alcohol and/or an SUD in Atlanta, GA.	VISTAs serve in capacity building roles (e.g., social media communications) and do not provide direct services or have lived experience with an SUD. Staff provided recovery coaching services.	Lived experience required: Yes Peer support specialists are required to have lived experience with an SUD. However, the organization has recovery coaches who are not required to have lived experience.

Organization & Project Type	Project Mission and Target Population	Role of AmeriCorps State and National Members/VISTAs	Lived Experience of Recovery Coaches*
Footprints **AmeriCorps VISTA**	**Mission:** Footprints fights the opioid epidemic by providing services through a coalition of community-based organizations, agencies, and institutions to those afflicted with SUDs and their family members. **Focus Population:** The organization serves individuals and families in Kansas City, MO, experiencing homelessness and those who are unemployed; formerly incarcerated; or low-income, including low-income veterans.	VISTAs do not provide recovery coaching and do not directly work with individuals with SUDs. VISTAs support other components such as youth initiatives and capacity building. Staff provided recovery coaching services.	Lived experience required: Yes There are two certifications represented by recovery coaches at this organization: Missouri Recovery Support Specialist (MRSS) and Certified Peer Specialist (CPS). A CPS has firsthand lived experience and is in recovery from an SUD; an MRSS has friends or family with SUDs. Recovery coaches were called "peer specialists."
Foundation for Recovery (FFR) **AmeriCorps State and National**	**Mission:** FFR provides recovery support services for mental health and SUD recovery to vulnerable teenaged and adult populations. **Focus Population:** Based in Nevada, 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.	FFR has AmeriCorps members serve as recovery coaches, delivering similar recovery support services and receiving the same training as the organization's coaches who were paid employees.	Lived experience required: Yes Recovery coaches are not required to have firsthand lived experience with an SUD or mental illness and are referred to as "peer recovery support specialists."

Organization & Project Type	Project Mission and Target Population	Role of AmeriCorps State and National Members/VISTAs	Lived Experience of Recovery Coaches*
Healing Action Network (Healing Action) **AmeriCorps State and National**	**Mission:** Healing Action provides access to preventative mental health services through case management, opioid education, therapeutic counseling, peer support, and community education. **Focus Population:** Serving 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.	AmeriCorps members provide case management, opioid education and naloxone distribution, therapeutic counseling, and community education, but do not deliver recovery coaching services. Staff provided recovery coaching services.	Lived experience required: Yes Recovery coaching services are provided by "peer support specialists" who are required to have lived experience with an SUD and trafficking.
Maggie's Place **AmeriCorps State and National**	**Mission:** Maggie's Place offers residential housing with extensive wraparound services and resources. Recovery coaching—through peer support staff—is one of those services. **Focus Population:** The organization serves pregnant women and new mothers experiencing homelessness in Phoenix, AZ, through their baby's first birthday. The organization continues to provide ongoing services after mothers leave Maggie's Place.	AmeriCorps members serve as "mobility mentors" and live in residential housing alongside the mothers, providing support and facilitating weekly community nights. They do not provide recovery coaching services and do not need to have lived experience with an SUD. Staff provided recovery coaching services.	Lived experience required: No Recovery coaches are alumni of Maggie's Place and have some lived experiences with SUDs. Recovery coaches are called "peer supports."

Organization & Project Type	Project Mission and Target Population	Role of AmeriCorps State and National Members/VISTAs	Lived Experience of Recovery Coaches*
NYC Peer Corps **AmeriCorps State and National**	**Mission:** NYC Peer Corps provides opioid overdose prevention education and connections to ongoing supports, leading to the long-term outcome of decreased mortality due to opioid overdose. **Focus Population:** The organization serves adolescents and young adults at risk for or struggling with opioid addiction and homeless in New York City.	AmeriCorps members provide peer support to participants.	Lived experience required: No The program strongly encourages individuals with lived experience to become recovery coaches. Coaches' lived experience was mixed—most had lived experience, and a few had family members with an SUD. Recovery coaches are called "peer corps members."
Recovery Corps **AmeriCorps State and National**	**Mission:** Recovery Corps places recovery coaches in multiple organizations, including recovery residence associations, recovery community organizations, treatment facilities, collegiate recovery organizations, and recovery high schools. **Focus Population:** 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.	AmeriCorps members serve as either recovery coaches, delivering peer support and recovery coaching services, or opioid response project coordinators.	Lived experience required: Yes Recovery coaches all have firsthand lived experience with an SUD. Recovery coaches are called "recovery navigators."

Organization & Project Type	Project Mission and Target Population	Role of AmeriCorps State and National Members/VISTAs	Lived Experience of Recovery Coaches*
RHOPE **AmeriCorps State and National**	**Mission:** RHOPE offers opioid abuse prevention and recovery services as well as economic opportunities across four different organizations–three of which were included in the site visit. **Focus Population:** The organization serves underserved citizens in Richmond, VA. The target populations served varied across organizations ranging from those seeking a higher education to adults who self-selected or were court ordered to participate in the program.	AmeriCorps members at all three sites included in the site visits provide recovery coaching to program participants with SUDs.	Lived experience required: Yes (at one site) The extent of lived experience varied across sites. Two sites had recovery coaches who were in recovery from an SUD and the other site was mixed, with some having personal lived experience or experience through family members. Recovery coaches are called "peer recovery specialists."

* Organizations differed in their definition of "lived experience." The spectrum of definitions is detailed in the Recovery Coaching Programs chapter of this report.

Recovery Coaching Models and Services

> *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

AmeriCorps State and National members and VISTAs were varied in their involvement with recovery coaching services; some were recovery coaches and others provided auxiliary support throughout the organizations. **Lived experience** is widely perceived as a key pillar of all organizations' recovery coaching models. However, the definition of "lived experience" within recovery coaching varied across organizations, as shown in exhibit ES-4.

One emergent finding on program implementation revealed that nine organizations provide **culturally appropriate services** to their participants by providing their coaches and staff with continuing education to promote the use of culturally appropriate language and styles of interaction, and by ensuring that the staff are racially/ethnically diverse to reflect the communities of their participants.

All 11 organizations seek to help participants to build themselves into who they want to be using a **holistic approach** to recovery. Holistic care entails a variety of in-house services and referrals for services such as financial, housing, employment, and mental health support. Although four organizations reported difficulty providing some of the services through partners, nine organizations worked successfully with partner organizations and/or providers in the area to facilitate client referrals for a range of services.

> *We don't want to only address the symptoms; we try to investigate [the] underlying conditions that can put that person in that situation. If you only treat the symptoms, the substance misuse, [and] don't investigate further what other issues [the] person is dealing with, your intervention will be very limited and most likely unsuccessful.*
>
> Project director

Organizations must consider state restrictions around needle programs. Ten organizations include **harm-reduction strategies** as part of their program. These include providing Narcan, fentanyl testing strips, medication-assisted treatment, medication disposal bags, and needle exchanges to program participants. Other harm-reduction strategies and programs described by organizations include confidential and at-home HIV and hepatitis C testing and treatment and Neonatal Abstinence Syndrome harm-reduction programming and treatment.

Recovery Coach Identification and Recruitment

Organizations use multiple methods to identify and recruit potential recovery coaches, including recruiting graduates of their own programs and candidates from other community recovery programs and trainings, community organizations not related to recovery, and schools and universities.

Most organizations (N = 10) required that recovery coaches were certified or in the process of getting certified in order to serve as recovery coaches. 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. In addition to certification requirements, some organizations required a minimum period (e.g., 1 year) of sustained recovery.

Two key barriers were noted in the hiring and retention of recovery coaches: background checks and stipends. Organizations identified the **criminal history background check** as a significant barrier to hiring recovery coaches, especially when background checks are included as part of the certification requirements. The lived experience of potential recovery coaches often includes a level of involvement with the justice system, and serving as an AmeriCorps member is a way to obtain skills when it proves challenging to find

other employment due to criminal history background checks. AmeriCorps service **members' stipend** is another reported barrier to hiring and retaining recovery coaches; only half of the project directors agreed or strongly agreed that the member stipend is sufficient.

Flexibility with criminal background checks and service member stipends can reduce barriers for hiring/retaining recovery coaches.

Certification and Training

Recovery coaching certifications are relatively new, and requirements continue to evolve as the SUD recovery space also continues to change. **The requirements varied by state and not all organizations required recovery coaches to be certified.** In general, the certification process included a combination of certifications tests, a period of training, and set hours of supervised service, with some exceptions for people with lived experience.

In addition to AmeriCorps and certification training, organizations also required **organization-specific training** for recovery coaches and other staff, including CPR/first aid, suicide prevention, effective communication, and trauma-informed training. Partnerships provided supplemental training for recovery coaches; three organizations provided training through local colleges. When asked about the training they received, 38 percent of recovery coaches reported that they received 9 to 16 hours of training and 32 percent reported 17 or more hours of recovery coach training. Most recovery coaches (59%) found their training to be "very helpful."

Program Monitoring and Tracking

Eighty-five percent of the director survey respondents reported that they have monitoring and oversight plans, including regular check-ins and continuous communication to combat the heavy emotional burden and **potential for burnout** among recovery coaches. Seventy percent of directors reported tracking relapses in their organizations' recovery coaches who were in recovery, but project directors from all organizations shared that **a 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 or a "restoration period" is given while the staff member focuses on their recovery.

> *We are a drug-free workplace, but we're recovery friendly as well.*
>
> Project director

Recovery Coaching Findings

Recovery coaches are the core of the recovery coaching programs. During the site visits, organizations described the types of activities that recovery coaches engage in; their motivations, successes, and challenges; and how organizations support recovery coaches.

Recovery Coaching Support

Recovery coaches across the participating organizations **demonstrated support in four key ways**: providing **emotional** support, **informational** support**, affiliational** support, **instrumental** support, and support for the **mental health needs** of program participants. Each of these types of support is described here.

Emotional support is a key component of recovery coaching in which a recovery coach listens to program participants, shows concern, and provides empathy in, for example, mentoring sessions or support groups. Recovery coaches play a key role helping participants to learn healthy coping mechanisms when experiencing

challenging emotions, which can be crucial for maintaining recovery from SUDs. Program participants described reaching out to contact their recovery coaches via text, phone, or in-person when they have the urge to use substances.

All organizations discussed the provision of various types of **informational supports**, such as connecting participants to community resources as well as sharing knowledge and information that support health and wellness. Participants were connected to services such as detox centers, laundry and shower services, art therapy, counseling, and medical services to address the diverse needs of participants in recovery.

> *The peer model is not 'Let me do for you'—it's, 'Let me stand next to you and support you.'*
>
> Project Director

Ten organizations provided examples of community supports, activities, and events (also known as **affiliational supports**) that are made available to participants either within the organization or via referrals. Common affiliational supports include recovery-friendly social activities and events, spaces to gather at the organization, and resources about Narcotics Anonymous or Alcoholics Anonymous. Many organizations have recovery-related support groups that offer opportunities to create community with other people in recovery. These include an anger management group, grief and relationship-building groups, and a music and wellness group class.

Recovery coaches at all but one organization also endorsed **instrumental supports,** which include referrals and connections to services related to housing (including emergency shelters, sober homes, and long-term housing), basic needs (including healthcare and furnishings), and self-sufficiency (including obtaining identification documents and finding employment).

Finally, all 11 organizations described serving participants with co-occurring SUDs and mental health diagnoses and/or undiagnosed **mental health challenges** such as post-traumatic stress disorder, depression, or anxiety. Recovery coaches connected participants to mental health supports including mental health classes and mental health-related partner organizations or referred participants to therapists, counselors, and psychiatrists.

Caseload, Duration, and Intensity of Services

Recovery coaches were highly varied in their caseloads, with 52 percent working with anywhere from 5 to 20 clients per week. There was also a wide range in reported frequency of client sessions; while more than 58 percent of recovery coaches reported that they see each participant at least once a week, 19 percent cited seeing clients fewer than two times per year.

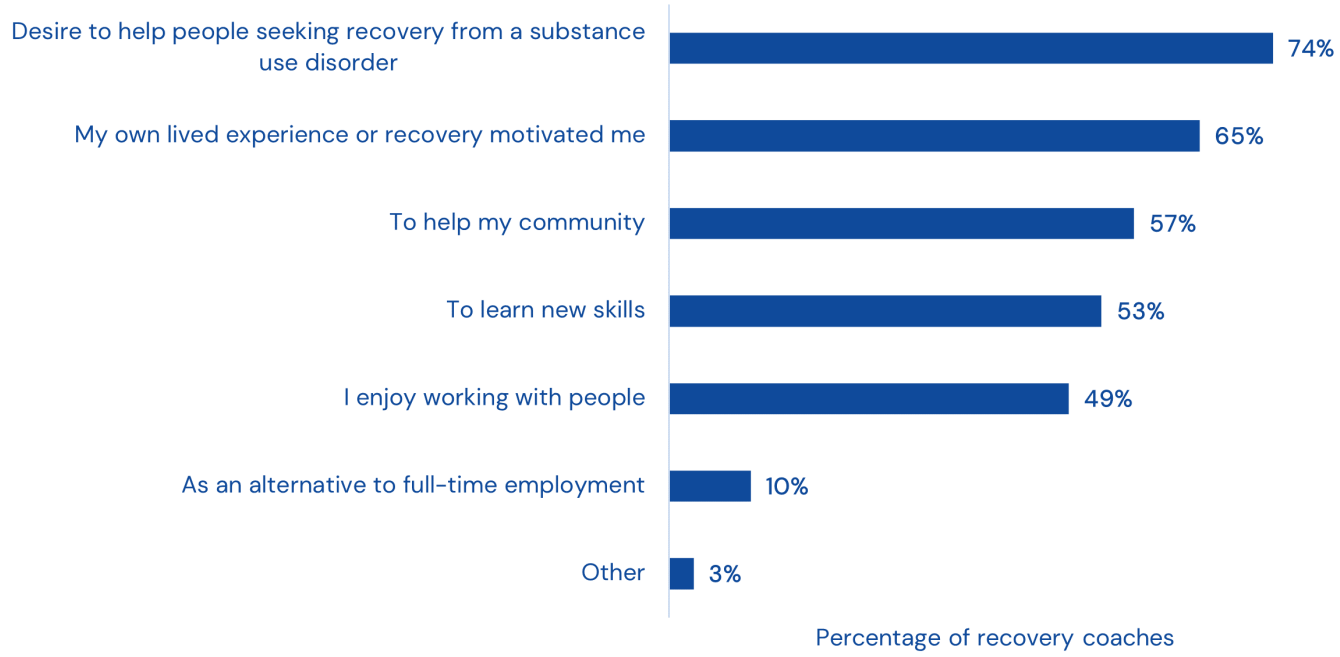
During site visits, recovery coaches were asked to estimate how many program participants they worked with each day and their average caseload. The caseload and intensity of services varied based on the recovery coach's situation, the types of services provided by the organization, and the geographic location.

Reasons for Becoming a Recovery Coach

Recovery coaches self-reported various reasons for becoming a recovery coach, with the two most common reasons being: the desire to help people seeking recovery from an SUD (74 percent) and that they were motivated by their own lived experience or recovery (65 percent) (exhibit ES-5). Qualitative findings aligned with these survey findings. Recovery coaches reflected on how their own lived experience with an SUD motivated them to become a recovery coach. Personal experiences such as having a family member with an

SUD or their own experiences with hardships such as homelessness were cited as inspirations for pursuing recovery coaching roles.

EXHIBIT ES-5.—Reasons reported for becoming a recovery coach (N=72)



Source: Recovery Coach Survey: "Why did you choose to become a recovery coach?"

Challenges and Solutions

Recovery coaches face significant challenges amidst working with individuals with SUDs. For example, program participants may overdose while receiving treatment. This can be emotionally devastating for recovery coaches while also presenting a challenge for coaches with a history of substance use to maintain their own sobriety through such experiences. One recovery coach shared that their organization has a ceiling covered with doves with the names of people who have died of an overdose as it sends a powerful message to visitors and program staff alike. Coaches discussed having to remove themselves from a session at times to ensure their own emotional self-care when their own traumas were triggered.

Other challenges were related to the site location and connecting to participants' culture and age backgrounds. Recovery coaches explained that working as a coach in a partner organization's space poses challenges to their authority and access to resources, and in some geographic areas, the community itself presents barriers to care through stigma and misconceptions about SUDs. Culture played a role in other ways too, as recovery coaches at three organizations stated that a barrier was working with different cultures and ages of their participants.

Support for Recovery Coaches

To deal with the many inherent challenges associated with serving as a recovery coach, all **organizations reported that they provide targeted support to help recovery coaches** to do their job and maintain their sobriety. Across organizations, recovery coaches found that recovery coach group chats and regular group meetings, check-ins and support from supervisors, and a supportive environment throughout the organization

were helpful when facing the challenges of working as a recovery coach. Several recovery coaches spoke to **the importance of having peers** with whom to work through problems and emotions related to their work because "it gets kind of lonely; when bad things happen, it feels even more so."

Program Outcomes

Organization Outcomes

The main outcomes for organizations included organizational capacity to provide services, ability to leverage grant financial support, and collaboration with partners and community resources, as assessed through survey responses from 20 program directors and interviews/focus groups with 35 program directors.

The involvement of VISTAs and AmeriCorps members directly affect organization budget and capacity. Project directors stated benefits such as increased access to services for clients, increased visibility of their programming within their community and specifically in rural regions, and greater organizational capacity to "tackle the multiple public health issues" as a result of AmeriCorps financial support and technical assistance.

Project directors were mixed in degree of agreement with their **program's ability to leverage grant financial support,** with 70 percent agreeing or agreeing strongly and 30 percent disagreeing or strongly disagreeing. All organizations reported the use of outside grant support to fund their services through private and/or public funding in addition to AmeriCorps funds, however, none of the organizations received a federal opioid development grant. One organization reported that they would not have a program if it were not for support from AmeriCorps.

Seventy-five percent of project directors reported high levels of agreement with the statement, "My **program is able to collaborate with partners, organizations, and community resources.**" Organizations facilitated connections to a range of holistic care services for their clients.

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, as assessed through survey responses from 72 coaches and interviews/focus groups with 47 coaches.

Recovery coaches rated their changes in knowledge, attitudes, and behaviors since becoming a coach on a 5-point scale ("increased greatly," "increased," "stayed the same," "decreased," or "decreased greatly"). **Across the 7 items, 85–98 percent of coaches reported the knowledge, attitude or skill "increased" or "increased greatly," indicating a strong agreement that they have experienced a multitude of benefits since becoming a recovery coach.**

> *I think [communication with other partners] helps us serve clients much better. And we're sharing resources. One of the purposes of meeting is to say, 'What are the issues that you're seeing?' And as a group we put our heads together and say, 'How are we going to fix this?'*
>
> Partner

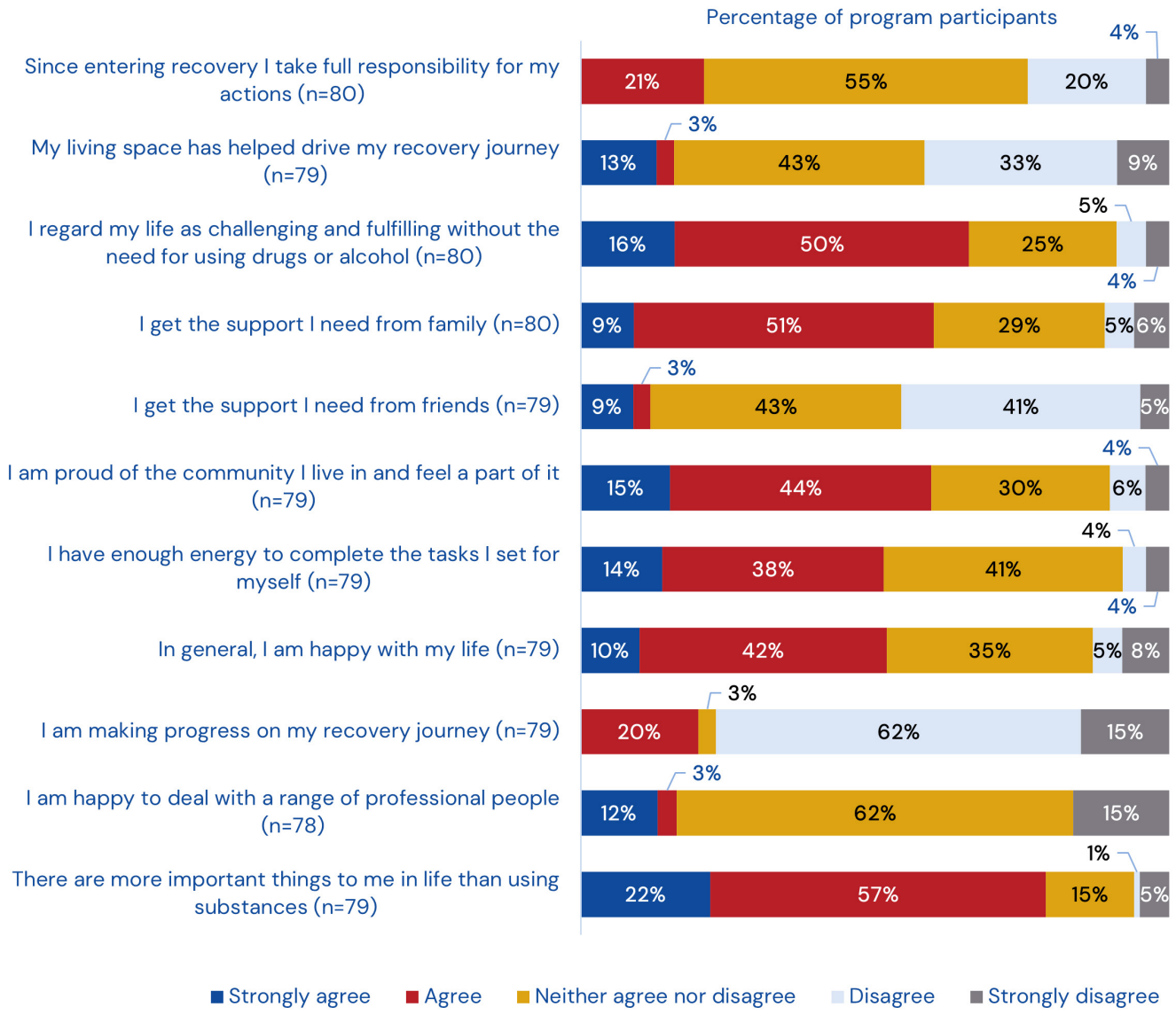
During interviews and focus groups, recovery coaches and directors from seven organizations expressed how recovery coaching helps coaches in recovery from an SUD maintain their recovery. Their role as a coach supports their own recovery because they serve as a **role model** to others and that gives them a **sense of purpose**.

Program Participant Outcomes

The main outcomes for program participants included recovery capital, attendance to physical and behavioral health services, and incidence of substance use, as assessed through survey responses from 83 program participants and interviews/focus groups with 70 program participants.

Recovery capital comprises an individual's internal and external resources that help to enhance capacity for and commitment to living a sober life. Survey items adapted from the validated Brief Assessment of Recovery Capital (Vilsaint et al., 2017) measured the program participants' self-reported recovery capital on a 5-point scale ranging from strongly disagree (1) to strongly agree (5). The scores were averaged rather than summed for each respondent as a strategy to include as much data in analysis as possible when missing data were present. This study's sample had a mean score of 3.2 (standard deviation [SD]=0.7) and a range of 1.18–4.82. The sample's responses for each recovery capital survey item are summarized in exhibit ES-6. Promisingly, most participants agreed or strongly agreed with statements such as "I regard my life as challenging and fulfilling without the need for using drugs or alcohol" and "There are more important things to me in life than using substances." However, there was a wide range of responses across the items; for instance, 77 percent of respondents disagreed or strongly disagreed with the statement that they were making progress on their recovery journey. This range in responses suggests that multiple, complex dimensions of perceived self-efficacy may exist for program participants.

EXHIBIT ES-6.—Program participant responses to recovery capital survey items



Source: Program Participant Survey

The descriptive statistics for recovery capital were complemented quantitatively by regression models to test hypotheses that more time spent with a recovery coach would be significantly associated with higher recovery capital. The number of hours spent weekly with a recovery coach was significantly associated with recovery capital; **results suggest a statistically significant association in which participants that self-report spending 9–16 hours/week with their recovery coach had on average a 1-point higher mean recovery capital score (range 1–5) than those who spent less than 1 hour/week with their coach** (b = 1.01, std. error = 0.47, p-value = 0.03), after adjusting for confounding from gender. Given the range of recovery capital scores, this is considered a large effect. It is not yet clear whether this 9–16 hour category represents an optimal "dose" for recovery coaching. More research is needed with larger samples to replicate these findings and to try assessment and analytical techniques using number of hours as a continuous variable or

exploring other categorical demarcations (e.g., 9–12 hours vs. 12–14 hours). However, this evaluation fills a gap in empirical evidence for the efficacy of greater time spent with recovery coaches on recovery capital and sets a foundation for more research. Findings from interviews and focus groups mainly align with and complement the survey findings related to recovery capital. Participants at eight organizations spoke about the **improvement in their quality of life.**

> *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 also cited other recovery coaching program benefits such as **improved self-esteem**, **increased knowledge**, and an **increased ability to navigate challenges** without using substances.

Evaluation Capacity Building

The overall purpose of the evaluation capacity building (ECB) project component was to enhance participants' capacity as evaluation practitioners. Twelve hour-long technical assistance sessions were delivered on a monthly basis. ECB sessions were divided into three modules: (1) Planning Evaluation; (2) Implementing Evaluation; and (3) Reporting and Using Evaluation. The curriculum was based on AmeriCorps ECB core curriculum with extensive tailoring to the recovery coaching context, especially through examples and discussion prompts that invited participants to apply evaluation concepts to their experiences. Twenty-four representatives—including project directors, program officers, clinical directors, and other organizational staff—attended at least one ECB session. The sessions also aligned with the goals of the current evaluation by helping grantees to understand their participation in the evaluation. For example, ECB sessions on rigorous survey development contributed to participants' ability to provide constructive feedback on draft instruments.

An external evaluator, BCT Partners, conducted a mixed-methods evaluation of the ECB sessions. Satisfaction was assessed at the end of each session with a range of N = 2 to N = 8 responses per session. All sessions had a mean satisfaction rating higher than 4 (on a scale of 1 to 5 where 5 signified "very satisfied"), suggesting **generally high levels of self-reported satisfaction** with the sessions. Participants gave a score of 5 to three sessions: Preparing to Collect Data, Evaluation Reporting, and Using Evaluation for Program Improvement and Continuous Learning.

In open-ended feedback, a major theme was that participants liked the opportunities for discussion and interaction. Participants also shared appreciation for learning about **data collection strategies**, especially those that minimize respondent burden and/or capitalize on administrative data they already collect, as collecting data from their program participants is a noted difficulty.

According to the N = 5 participants who completed the pre- and post-curriculum surveys, perceived knowledge of evaluation topics increased for 10 out of 13 topics. The topics with the greatest increases in perceived knowledge were: identifying common data analysis terms, identifying strategies to collection information from participants, recognizing how to use evaluation findings to improve a program, recognizing how quantitative and qualitative analysis is performed, and recognizing when data should be collected.

Discussion of Findings

Recovery coaching is a promising substance use treatment approach that needs more examination in its implementation and associated outcomes. This study's purpose was to deepen understanding of AmeriCorps projects' implementation of recovery coaching services, and to add to the dearth of evidence on its associations with positive outcomes for coaches and program participants.

In general, this evaluation documented the recovery coaching programs that were successful in many ways. They were implemented across diverse regions and for diverse and challenging-to-treat target populations. Organizations leveraged paid staff, AmeriCorps State and National members, and VISTAs to support the programs by providing direct services and/or contributing to other organizational activities. Notably, interviews, focus groups, and surveys with coaches, project directors, and program participants showed the many benefits of recovery coaching. Programs recognize clients as individuals through **holistic and culturally appropriate services**, which may increase treatment effectiveness (La Roche & Christopher, 2009; SAMHSA, 2006). Culturally competent treatment practices may also carry health equity implications; for example, older Black Americans are less likely to finish their course of substance use treatment compared to their White or Hispanic American counterparts (Grooms & Ortega, 2022) and the implementation of tailored care may improve treatment of populations disproportionately affected by poorer substance use treatment outcomes.

Lived experience was another cross-cutting theme in this evaluation's findings, carrying implications for recovery coach hiring requirements and practices. Clients, project directors, and coaches believed lived experience with substance use recovery among coaches is helpful for building rapport and client engagement, which can in turn improve treatment engagement and outcomes. Hiring practices that disqualify candidates based on criminal history may impede otherwise qualified coaches from being hired.

Finally, **recovery capital** was a key evaluation question in this study that garnered important findings. The wide range of self-reported recovery capital across individuals serves as an important reminder that programs should account for recovery capital in addressing the gaps and needs within their populations of focus. This evaluation adds to the evidence base by demonstrating that the **number of hours spent weekly with a recovery coach** was statistically significantly associated with recovery capital scores, but more research is needed to confirm an optimal dose.

A key priority to further this work and to attribute any positive outcomes to recovery coaching specifically is the 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. 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 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, de-identifying survey data). A greater understanding of **organizations' confidentiality concerns** can help AmeriCorps to address those concerns and to open up greater collaboration that allows for rigorous and effective program evaluation.

Limitations

The findings are vulnerable to several notable biases. The small sample sizes, purposive sampling procedures, and self-selection bias (along with lack of data on those who were recruited but declined to participate) limit our ability to assess the representativeness of our data and also limit our ability to generalize study findings. Survey questions were generated for the current study's purposes and findings may lack external validity; one exception was the use of the validated Brief Assessment of Recovery Capital (BARC-10; Vilsaint et al., 2017) in informing this study's 11-item survey to measure the program participants' self-reported recovery capital.

Despite these limitations, rich mixed-methods data revealed common themes and variability across programs, and this report highlights those key findings for future research to build upon.

Lessons Learned About Conducting Evaluations of Recovery Coaching Programs

This section briefly highlights some of the key lessons learned that may be applied to future evaluation endeavors with recovery coaching programs or with populations receiving treatment for SUDs.

Participant recruitment was challenging and sample sizes were small. Site visits conducted in the earliest stages of an evaluation can provide researchers the opportunity to address organizations' concerns about ethics and confidentiality before contact information for potential participants are shared. Direct survey distribution by study staff can relieve evaluation-related burden for organizations and allow for response rate calculation and follow-up procedures to enhance response rates. Organizations can also 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 interact directly with study materials and staff.

Concerns about confidentiality should be addressed early in the evaluation process and in numerous ways. Quelling concerns about privacy and confidentiality (e.g., anonymizing any quotations used in reports, data security procedures) may encourage more invested recruitment and tracking efforts. Improved incentivization may motivate greater participation and response.

Flexibility with data collection methods is important. In-person site visits were supplemented by virtual interviews/focus groups when participants' schedules were not amenable to the in-person interview times. Session durations were sometimes shortened to accommodate potential participants' availability. Flexible data collection allowed more participation and the inclusion of more voices in the data that informed our findings.

Optimize each encounter with participants to achieve as many data collection goals as possible. It was beneficial to distribute paper versions of the surveys at the time of focus/groups interviews to maximize survey response rates, particularly with program participants. Participants were also provided their gift card incentive at the time of paper surveys and interviews, which encouraged participation. The opportunity to turn in surveys to study staff at the end of the interviews created a streamlined process that also abated concerns about program staff/other program participants having access to their confidential survey responses.

Explore both within- and across-site differences. Some organizations had multiple sites that varied in program scope and target population. Organizations with multiple sites specified for study staff which sites would be available for study participation. In addition, comparisons across organization sites were beyond the scope of this evaluation but may garner valuable insights. Future studies could explore implementation and outcomes both within and across organizations, offering a more nuanced understanding of successes, challenges, and outcomes for different implementation contexts.

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). Early research suggests public health measures such as mandatory stay-at-home orders during the pandemic 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[1] 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 the approach of recovery coaching.

[1] 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.

Recovery Coaching

Recovery coaching is the process in which a nonclinical professional typically provides guidance to individuals with SUDs by helping them access care and supporting them in the removal of barriers to recovery (Zandniapour et al., 2020).

The primary purpose of recovery coaches is to function in a support role and to provide several different types of assistance, including:

- Emotional support – listening, demonstrating empathy, or showing concern.
- Informational support – providing connections to information and referrals to community resources that support health and wellness.
- Affiliational support – providing connections to recovery community supports, activities, and events.
- Instrumental support – providing concrete supports, such as for housing or employment (Center for Substance Abuse Treatment, 2009; SAMHSA, 2017).

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).

Recovery Coach Terminology

A wide range of terms is used to refer to the role of a recovery coach in the substance use space including, but not limited to: "peer support specialists," "navigators," "peer coaches," and "recovery mentors." The term "peer" often refers to a recovery coach who has some degree of shared experience with an SUD and/or recovery, such as being in recovery themselves or knowing someone in recovery. This emphasis on lived experience can be impactful in improving the recovery experience. Individuals who have walked similar paths possess a unique understanding of the challenges, setbacks, and victories inherent in the recovery journey. Their firsthand knowledge enables them to offer not just guidance but genuine empathy and connection, fostering trust and motivation within those seeking recovery (Eddie et al., 2019). However, not all recovery coaches have lived experience, and the term "peer" in recovery coaching is not consistently reserved for those with lived experience; due to this heterogeneity in terms to refer to the role of a recovery coach, this report operationalizes the term “recovery coaching” to include recovery coaching delivered by state-certified coaches as well as other forms of coaching and support provided by non-certified coaches, peer support specialists, navigators, mentors, and support staff following a recovery coaching model for SUD recovery.

Prior Research on Recovery Coaching

Key research on recovery coaching emerged in the early 2000s in response to recognition from the broader recovery field regarding the need for long-term support. Most published literature on this topic uses quasi-experimental design or descriptive approaches such as combinations of qualitative, survey, and administrative data analysis. Few studies use traditionally rigorous designs such as randomized controlled trials; however,

systematic reviews note that these designs may not be suited to recovery coaching programs given the many settings in which they are delivered (Bassuk et al., 2016; Eddie et al., 2019).

Literature on recovery coaching has demonstrated a positive effect of recovery coaching interventions on outcomes such as substance use, housing stability, justice-involved status, mental and physical health, and uptake of services related to recovery from an SUD (Bassuk et al., 2016; Eddie et al., 2019). The majority of recovery coaching programs and the literature on recovery coaching also highlight the high frequency of individuals seeking recovery from multiple substances. Services provided by recovery coaching 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).

In a spanning literature review on recovery support services in the United States completed by Massachusetts General Hospital and Harvard Medical School, Eddie and colleagues (2019) noted that the services delivered varied due to the diversity of program settings and populations of focus. Additionally, the time and frequency of service delivery varied according to the setting and needs of the service population. While it is difficult to compare the effect of such heterogeneous interventions, common themes exist on the importance of recovery coaches 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 multiple peer-based recovery programs are scarce due to difficulty in generalizing findings, meaningful insights can still be drawn from the literature that examines peer-based treatment interventions.

A quasi-experimental study of adults with an SUD participating in a recovery coaching 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 for participants when compared to participants in the previous year who did not participate in recovery coaching. In addition to overall decreases in relapse, longer durations spent in recovery coaching have demonstrated longer durations of sobriety (Kamon & Turner, 2013).

Recovery coaching programs have also demonstrated successful outcomes in tandem with medication assisted treatment clinics. In partnership with clinics across Pennsylvania, recovery coaches helped program participants to transition across various care settings and referred participants to community support resources (Kawasaki et al., 2019). In this role, the recovery coaches functioned to remove barriers to medically assisted treatment and community care by organizing and providing transportation, appointment scheduling, patient advocacy, and establishing connections to recovery-oriented meetings. The study found that the addition of supportive recovery coaches reduced the turnaround time for medication assisted treatment patient intake appointments from 2 weeks to 1–2 days.

Numerous studies have found that people in recovery may prefer the recovery coaching 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 recovery coaching services as 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 recovery coaching 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 (e.g., college), 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 positive effect of recovery coaching approaches to maintain long-term recovery and to increase favorable participant outcomes (Laudet et al., 2016).

Despite the promising evidence briefly described here, the evaluation of recovery coaching as a substance use treatment strategy is still in nascent phases and more knowledge is needed on its implementation and associated outcomes.

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. Most 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 coaching 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.

In summary, the foundational report on the use of 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 on the potential benefits of such programs. The current study aims to build upon the evidence base surrounding recovery programs; services provided; and outcomes of participants, recovery coaches, and participating organizations implementing a recovery coaching approach.

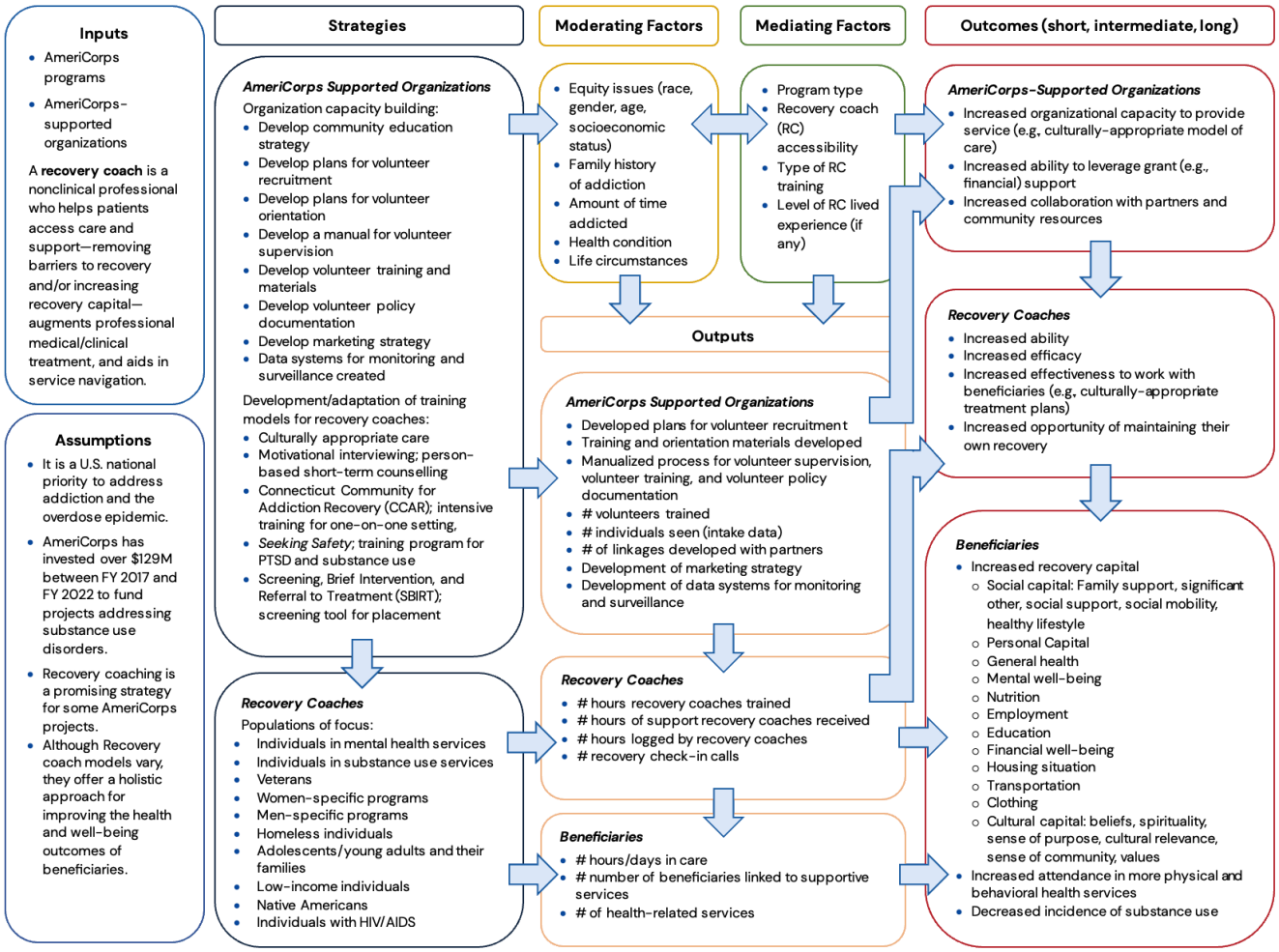
Overview of the Study

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-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 (exhibit 1-1) was developed based on a document review of several recovery coaching programs. The logic model outlines the relationships between recovery coaching 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 (e.g., the relationships between strategies and results or outputs and outcomes), and the relationships within the components (e.g., how strategies employed by organizations will influence those employed by recovery coaches and subsequently the program participants).

EXHIBIT 1-1.—Logic model



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 report improved knowledge, attitudes, and behaviors?
- To what extent do program participants improve their recovery capital when participating in recovery coaching?
- To what extent do program participants increase attendance to physical and behavioral health services when participating in recovery coaching?
- To what extent do program participants experience a decrease in substance use when participating in recovery coaching?

The Evolution of Data Collection to Include Two Cohorts

While the Methods and Data Sources chapter provides in-depth details of the study's methods, this section briefly summarizes the evolution of this study's data collection and reporting processes that resulted in two "cohorts" of participating organizations.

Recruitment for the study began in June 2021, starting with a review of 17 AmeriCorps project applications from FY 2020. Of those, 15 organizations met screening criteria and received an invitation to participate in the evaluation. Eight organizations initially agreed to participate, but four organizations dropped out before data collection was complete and the resultant data had small sample sizes, which limited the generalizability and reliability of the findings. The methods and results from this small sample were published on the AmeriCorps website as interim, preliminary "Cohort 1" findings (O'Conner et al., 2023) while the overall evaluation launched another data collection endeavor with a second cohort ("Cohort 2") to increase the final evaluation's sample size.

This additional cohort (Cohort 2) evaluated AmeriCorps organizations with FY 2021 and FY 2022 projects and the final sample of the study is the combination of Cohort 1 and Cohort 2 participation organizations' data. This report presents the methods and findings of this final sample. To complement the Cohort 1-only preliminary findings already published, this report also includes Cohort 2-specific survey findings in Appendix C.

Organization of This Report

The Methods and Data Sources chapter details the methodology used for this study, including the evaluation design, the data sources, and the analysis methods. The Recovery Coaching Programs chapter 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). The Recovery Coaching chapter presents the findings related to recovery coaching activities (e.g., duration and intensity of services; and referrals to other supportive services). The Program Outcomes chapter presents the results of the analyses of the outcomes for each group (organizations, recovery coaches, and program participants). The Evaluation Capacity Building chapter 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 (Discussion and Lessons Learned chapter). The appendices contain information about the logic model, data collection instruments, and any state certification requirements for recovery coaches that may exist for the report's organizations.

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. The evaluation used a mixed-methods approach to examine the implementation of recovery coaching models across different 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 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 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). The study was approved by the ICF Institutional Review Board (IRB), and all evaluation activities were conducted according to IRB requirements.

Study Sites

In spring 2021 and fall 2022 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 and 34 project applications from FY 2021 and FY 2022 to ICF. This included AmeriCorps State and National and AmeriCorps VISTA projects. The project applications were reviewed for terms such as "peer recovery coach," "recovery coach," and "opioid." Project applications were assessed for organizations' use of a recovery coaching model as well as organizations' unique structures, approaches, and populations served. The points of contact in the project applications 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. Initially, 17 organizations agreed to participate, but 6 organizations withdrew from the study in the months that followed. Four 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

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 address community challenges where the need is greatest while building their professional skills and earning additional benefits.

capacity building component. These challenges in recruiting and retaining participants demonstrated the difficulty in studying substance use and recovery populations. 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 11 organizations—7 AmeriCorps State and National grantees and 4 AmeriCorps VISTA sponsors—located in New York, Georgia, Tennessee, Virginia, Ohio, Illinois, Minnesota, Missouri, Arizona, and Nevada (see exhibit 2-1 for map highlighting states with participating programs). The organizations varied in the geographic regions and target populations they served, the role of AmeriCorps State and National members/VISTAs, the terminology used for those performing the services of a recovery coach, and the applicability of lived experience for recovery coaches. Exhibit 2-2 summarizes each organization. Additional details on the role of AmeriCorps members/VISTAs and the degree to which recovery coaches had lived experience with recovery from an SUD are discussed in the Recovery Coaching Programs chapter findings on recovery coach programs.

EXHIBIT 2-1.—Map showing states with participating organizations

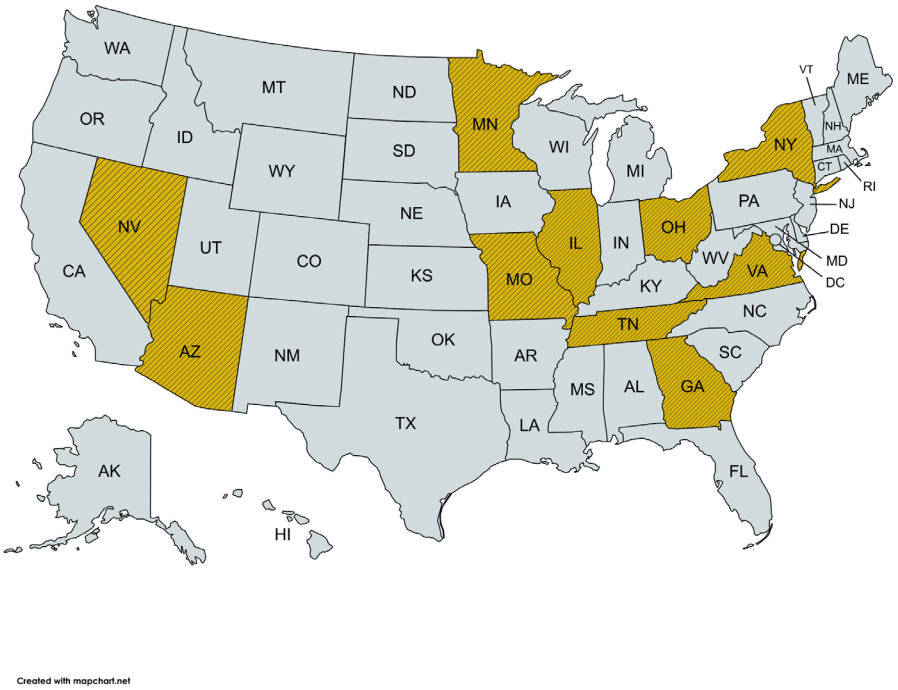


EXHIBIT 2-2.—Overview of participating organizations

Organization & Project Type	Project Mission and Target Population	Role of AmeriCorps State and National Members/VISTAs	Lived Experience of Recovery Coaches
Above and Beyond Family Recovery Center (AnB) **AmeriCorps VISTA**	**Mission**: 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. **Focus Population:** Based in Illinois, AnB serves clients from Chicago and neighboring suburbs, with most clients coming from Chicago's West Side. AnB's populations 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).	VISTAs support project management and capacity-building services related to housing and employment, community outreach, and education. Staff provided recovery coaching services.	Lived experience required: Yes Recovery coaches all have firsthand lived experience with an SUD. Recovery coaches are called "certified recovery support specialists" and are paid staff.
Align9 **AmeriCorps VISTA**	**Mission:** Align9 is an onramp to coordinated services through a faith-based 12-step recovery program. Services are offered at local churches, including housing, legal, Certified Peer Specialist (CPS), food, and employment services. **Focus Population:** Align9 serves individuals who have had or are currently suffering from substance use disorder (SUD). The organization is focused on meeting local community needs related to the devastating effects of the opioid epidemic in the Counties of Roane, Loudon, Morgan, and Meigs in Tennessee.	VISTAs support Align9 by supporting recovery coach development, coordinating social media communications, and assisting with health programming. Staff provided recovery coaching services.	Lived experience required: No Recovery coaches are not required to have firsthand lived experience with an SUD. Many coaches identified as being in recovery in a broad sense: "We are all in recovery from something." Recovery coaches are called "peer recovery coaches."

Organization & Project Type	Project Mission and Target Population	Role of AmeriCorps State and National Members/VISTAs	Lived Experience of Recovery Coaches
County of Washington **AmeriCorps State and National**	**Mission:** The County of Washington provides recovery coaching and develops recovery infrastructure, including recovery housing, transitional housing, evidence-based self-management programs, and community improvement projects. The initial focus is on wellness activities and sustained recovery from addiction. **Focus Population:** The organization serves individuals in western West Virginia and eastern Ohio who have had or are currently suffering from chronic illness.	AmeriCorps members serve as peer support workers providing recovery coaching services and other connections to resources to program participants.	Lived experience required: Yes Recovery coaches are required to have firsthand lived experience with an SUD and/or a mental illness, and are called "peer recovery support workers".
Covenant Community **AmeriCorps VISTA**	**Mission:** Covenant Community hosts a residential intensive treatment program that uses a therapeutic community model to assist its residents in overcoming their SUDs. **Focus Population:** The organization serves men experiencing homelessness and recovering from alcohol and/or a substance use disorder in Atlanta, GA.	VISTAs serve in capacity building roles (e.g., social media communications), and do not provide direct services or have lived experience with an SUD. Staff provided recovery coaching services.	Lived experience required: Yes Peer support specialists are required to have lived experience with an SUD. However, the organization has recovery coaches who are not required to have lived experience.

Organization & Project Type	Project Mission and Target Population	Role of AmeriCorps State and National Members/VISTAs	Lived Experience of Recovery Coaches
Footprints **AmeriCorps VISTA**	**Mission:** Footprints fights the opioid epidemic by providing services through a coalition of community-based organizations, agencies, and institutions to those afflicted with SUDs and their family members. **Focus Population:** The organization serves individuals and families in Kansas City, MO, experiencing homelessness and those who are unemployed; formerly incarcerated; or low-income, including low-income veterans.	VISTAs do not provide recovery coaching and do not directly work with individuals with SUDs. VISTAs support other components such as youth initiatives and capacity building. Staff provided recovery coaching services.	Lived experience required: Yes There are two certifications represented by recovery coaches at this organization: Missouri Recovery Support Specialist (MRSS) and Certified Peer Specialist (CPS). A CPS has firsthand lived experience and is in recovery from an SUD; an MRSS has friends or family with SUDs. Recovery coaches were called "peer specialists."
Foundation for Recovery (FFR) **AmeriCorps State and National**	**Mission:** FFR provides recovery support services for mental health and SUD recovery to vulnerable teenaged and adult populations. **Focus Population:** Based in Nevada, 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.	FFR has AmeriCorps members serve as recovery coaches, delivering similar recovery support services and receiving the same training as the organization's coaches who were paid employees.	Lived experience required: Yes Recovery coaches are not required to have firsthand lived experience with an SUD or mental illness and are referred to as "peer recovery support specialists."

Organization & Project Type	Project Mission and Target Population	Role of AmeriCorps State and National Members/VISTAs	Lived Experience of Recovery Coaches
Healing Action Network (Healing Action) **AmeriCorps State and National**	**Mission:** Healing Action provides access to preventative mental health services through case management, opioid education, therapeutic counseling, peer support, and community education. **Focus Population:** Serving 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.	AmeriCorps members provide case management, opioid education and naloxone distribution, therapeutic counseling, and community education, but do not deliver recovery coaching services. Staff provided recovery coaching services.	Lived experience required: Yes Recovery coaching services are provided by "peer support specialists" who are required to have lived experience with an SUD and trafficking.
Maggie's Place **AmeriCorps State and National**	**Mission:** Maggie's Place offers residential housing with extensive wraparound services and resources. Recovery coaching—through peer support staff—is one of those services. **Focus Population:** The organization serves pregnant women and new mothers experiencing homelessness in Phoenix, AZ, through their baby's first birthday. The organization continues to provide ongoing services after mothers leave Maggie's Place.	AmeriCorps members serve as "mobility mentors" and live in residential housing alongside the mothers, providing support to the mothers and facilitating weekly community nights. They do not provide recovery coaching services and do not need to have lived experience with an SUD. Staff provided recovery coaching services.	Lived experience required: No Recovery coaches are alumni of Maggie's Place and have some lived experiences with SUD. Recovery coaches are called "peer supports."

Organization & Project Type	Project Mission and Target Population	Role of AmeriCorps State and National Members/VISTAs	Lived Experience of Recovery Coaches
NYC Department of Health and Mental Hygiene AmeriCorps State and National	**Mission:** NYC Peer Corps provides opioid overdose prevention education and connections to ongoing supports, leading to the long-term outcome of decreased mortality due to opioid overdose. **Focus Population:** The organization serves adolescents and young adults at risk for or struggling with opioid addiction and homeless in New York City.	AmeriCorps members provide peer support to participants.	Lived experience required: No The program strongly encourages individuals with lived experience to become recovery coaches. Coaches' lived experience was mixed, most had lived experience, and a few had family members with an SUD. Recovery coaches are called "peer corps members."
Recovery Corps **AmeriCorps State and National**	**Mission:** Recovery Corps places recovery coaches in multiple organizations, including recovery residence associations, recovery community organizations, treatment facilities, collegiate recovery organizations, and recovery high schools. **Focus Population:** 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.	AmeriCorps members serve as either recovery coaches, delivering peer support and recovery coaching services, or opioid response project coordinators.	Lived experience required: Yes Recovery coaches all have firsthand lived experience with an SUD. Recovery coaches are called "recovery navigators."

Organization & Project Type	Project Mission and Target Population	Role of AmeriCorps State and National Members/VISTAs	Lived Experience of Recovery Coaches
RHOPE **AmeriCorps State and National**	**Mission:** RHOPE offers opioid abuse prevention and recovery services, as well as economic opportunities across four different organizations–three of which were included in the site visit. **Focus Population:** The organization serves underserved citizens in Richmond, VA. The target populations served varied across organizations ranging from those seeking a higher education to adults who self-selected or were court ordered to participate in the program.	AmeriCorps members at all three sites included in the site visits provide recovery coaching to program participants with substance use disorders.	Lived experience required: Yes (at one site) The extent of lived experience varied across sites. Two sites had recovery coaches who were in recovery from an SUD and the other site was mixed, with some having personal lived experience or experience through family members. Recovery coaches are called "peer recovery specialists."

Data Sources and Data Collection

This study had three data sources: 1) organization program documents; 2) surveys of key organization informant groups; and 3) site visits with the 11 organizations. Each data source and the data collection procedures are described here.

Program Documents

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

Surveys

Survey instruments 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 A). The protocols were customized to each organization (e.g., including the name of the organization in the survey). Additional details about the survey instruments are as follows (see also Appendix B):

- Project director/manager surveys assessed organizational capacity, staff recruitment, ability to leverage grant financial support, and collaboration with partners and community resources. In some instances, partners with an active role in program implementation also completed the project director/manager survey.
- Recovery coach surveys assessed knowledge, attitudes, and behaviors; activities and services provided; experiences with the organizations; and experiences with program participants.
- Program participant and comparison group surveys assessed recovery capital, attendance to physical and behavioral health services, incidence of substance use, and experiences interacting with organizations and recovery coaches.

The original plan was to launch a baseline survey and a follow-up survey 1 year later to capture changes in outcomes, but due to low response rates at the beginning of the project's evaluation, the original design was modified and the follow-up data collection period was instead used to collect data again from all potential participants. In the few instances where an individual completed both the baseline and follow-up surveys before the data collection was modified, only the most recent survey was kept. After the adjustment to the study design, organizations that had yet to begin survey data collection received a single retrospective survey. All data collected between November 2021 and January 2024 were ultimately treated as pooled data.

Study staff were able to directly distribute surveys to potential participants for the few organizations that felt comfortable sharing those contacts. For other organizations, their staff distributed survey links and/or paper surveys themselves. Organizations received paper surveys if they specifically requested them or if they hosted in-person site visits with the study team in fall 2023 in which paper surveys were brought on site and disseminated to additional respondents as applicable.

Initially, only comparison group respondents were offered $25 Amazon gift cards as compensation for participation as a targeted strategy to boost participation since study staff anticipated particularly low numbers with this subgroup. Project directors were also asked to help identify and reach out to potential comparison participants. Despite these strategies, very few comparison group surveys were collected. Gift cards were also distributed to program participants and recovery coaches in later stages of the evaluation to

increase participation rates in these respective groups as well. Exhibit 2-3 presents the number of respondents per survey by participating organization.

EXHIBIT 2-3.—Number of surveys completed for each key informant group by participating organization*

Organizations	Director/Manager	Recovery Coach	Program Participant	Comparison Group	AmeriCorps Member
Above and Beyond (AnB)	2	5	2	12	1
Align9	1	2	2	-	-
County of Washington	2	7	-	-	3
Covenant Community	5	5	11	-	-
Footprints	2	3	1	-	4
Foundations for Recovery (FFR)	2	4	2	-	-
Healing Action Network (Healing Action)	1	1	4	2	-
Maggie's Place	2	3	11	-	-
NYC Department of Health and Mental Hygiene	1	-	-	-	20
Recovery Corps	1	29	14	4	-
RHOPE	2	13	36	2	-
Total	**20**	**72**	**83**	**20**	**28**

* These are the number of valid surveys, defined as 50-plus percent complete.

It is important to note that due to organizations' general preference not to share contact information for potential participants, the majority of surveys were distributed by the organization in a way that forbade the calculation of response rates.

Survey Sample

Exhibit 2-4 presents the demographic characteristics for the survey respondent groups. Over half of recovery coaches (57 percent) were female and were White (57 percent), and most were non-Hispanic (85 percent). The majority of recovery coaches (56 percent) were between the ages of 30 and 49. One-quarter (25 percent) of recovery coaches were college graduates.

Of the program participants, there was a relatively similar prevalence between male (48 percent) and female (36 percent) participants. More than 55 percent were White and 20 percent were Black or African American. Sixty-four percent identified as non-Hispanic, Spanish, or Latino/a. 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 higher educational attainment (85 percent).

EXHIBIT 2-4.—Demographic characteristics of recovery coaches and program participants (reported in percentages of total sample)

Characteristics	Recovery Coaches (N = 72)	Program Participants (N = 83)
Age	n = 68	n = 82
18–29 years old	8	8
30–39 years old	28	35
40–49 years old	28	24
50–59 years old	14	25
60–69 years old	14	5
70–79 years old	3	1
Gender	n = 69	n = 77
Male (including transgender men)	26	48
Female (including transgender women)	57	36
Nonbinary/nonconforming	4	2
Prefer to self-describe	7	6
Prefer not to say	1	0
Race	n = 56	n = 76
American Indian or Alaska Native	3	6
Asian or Pacific Islander	3	2
Black or African American	13	21
White	57	56
Other (please specify)	3	6
Don't know	0	1
Hispanic	n= 64	n = 62
Yes	6	10
No	85	64
Don't know	0	1
Prefer not to say	0	0
Highest grade completed	n = 69	n = 78
Some high school	3	8
High school graduate or equivalent	24	35
Some college or technical school	43	37
College graduate	25	13
Prefer not to say	1	0

Note: Totals may not add up to 100 due to rounding.

Site visits

The study team conducted virtual site visits for five organizations and in-person site visits for six organizations. In addition, virtual focus groups/interviews were also conducted to complement in-person focus groups/interviews as requested (for example, if a recovery coach could not attend the in-person focus group but wanted to participate). The site visits consisted of 60-minute in-depth interviews with organization project directors; 60-minute in-depth interviews and/or focus groups with recovery coaches; 30-minute structured interviews with partner organizations and AmeriCorps members; and 60-minute focus groups with program participants. Thirty-minute individual interviews were also conducted with program participants due to difficulty recruiting this participant group for 60-minute sessions. Program participants and recovery coaches were given $25 Amazon gift cards as an incentive to increase participation rates.

All project directors, recovery coaches, VISTAs and AmeriCorps State and National members, program participants, those in recovery but not receiving recovery coaching (i.e., comparison group members), and program partners were eligible and encouraged to participate. However, no comparison group members participated in the site visits. Exhibit 2-5 provides sample sizes for interviews and focus groups for the remaining participant groups.

At the beginning of each interview/focus group, research staff reviewed the IRB-approved consent statement. The consent statement included the purpose and content of the interview, the participant's rights, confidentiality, and data security practices. The research staff obtained the interviewee's informed consent (including consent to record the interview/focus group) for those who wished to participate. Interviews and the focus groups were guided by questions in the protocol and additional probes to facilitate discussion (see Appendix B). Interviewees were asked to describe in greater depth topics related to implementation, successes, challenges, and recommendations for program enhancements. The virtual interviews and focus groups were conducted using Microsoft Teams.

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 who were recruited in 2020, left the study. Remaining grantees interviewed in 2021 noted the negative effect the pandemic had on participants in their respective programs.

EXHIBIT 2-5.—Number of interviews/focus groups completed for each key participant group by organization

Organization	Project Directors	Recovery Coaches	AmeriCorps Members	Program Partners	Program Participants
Above and Beyond (AnB)	1	1	1	1	11
Align9	5	12	4	2	-
County of Washington	4	6	-	4	-
Covenant Community	5	4	1	2	11
Footprints	5	3	4	-	2

Organization	Project Directors	Recovery Coaches	AmeriCorps Members	Program Partners	Program Participants
Foundation for Recovery (FFR)	2	1	-	1	-
Healing Action Network (Healing Action)	1	1	3	1	1
Recovery Corps	1	2	-	-	-
RHOPE	4	12	-	-	21
Maggie's Place	6	2	12	-	24
NYC Department of Health and Mental Hygiene	1	3	-	-	-
Total	**35**	**47**	**25**	**11**	**70**

Outcome Measures

The study focused on outcome measures for organizations, recovery coaches, and program participants. Each outcome was captured by indicators used in instrument and protocol development (see exhibit 2-6).

EXHIBIT 2-6.—Outcomes and indicators

Group	Outcomes	Indicators
Organizations	Organizational capacity to provide services	Participating organizations' self-reported organizational capacity
	Ability to leverage grant financial support	• Participating organizations' self-reported ability to leverage resources • Participating organizations' receipt of funding or resources
	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	Knowledge, attitudes, and behaviors	Self-reported increase in knowledge, attitudes, and behaviors
	Opportunity of maintaining their own recovery	Self-reported increase in recovery coaches' ability to stay in recovery
Program Participants	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)

Group	Outcomes	Indicators
	Attendance to more physical and behavioral health services	The percentage of program participants who report increased participation in health- and mental health-related activities
	Incidence of substance use	The percentage of program participants who report they are not using opioids/drugs/alcohol

Analysis

Survey responses were analyzed using IBM SPSS Statistics and R software. In the case of duplicate survey responses, the study team used the most recent response. 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, quantitative analyses used pooled data from the 11 participating organizations. In addition, due to the limited number (N =20) of comparison respondents who do not receive recovery coaching, results for this respondent group are not included in this report (see Cohort 1 report for more characterization and analyses using comparison respondent data in the early phases of the evaluation). 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. In the absence of a comparison group, the program participants' data were analyzed as a series of regression models, detailed further in the Program Outcomes chapter.

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 or Dedoose 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 self-selected subset of recovery coaches and program participants within organizations, representing, in some cases, a subset of sites from the organizations, and the findings are therefore not generalizable to all respondents across/beyond the organizations. The study team did not interview all program staff, recovery coaches, or program participants at each 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. In some instances, an organization had multiple sites and the study team only visited a subset of the locations. For organizations with multiple sites, there was sometimes variation in the target populations and recovery coach approaches and services offered by each site. The variation across sites is not fully explored in this report as qualitative findings are reported at the organization level and not the site level. Therefore, the findings presented in this

report are subject to self-selection bias and should not be considered representative of all recovery coaches, program participants, or program partners.

Low participation rates for the recovery coach and program participant surveys limit the generalizability of findings. In addition to non-representative sampling, non-response bias jeopardizes the generalizability of findings. It was not possible to accurately determine response rates due to heterogeneity of survey distribution methods; for instance, some organizations' project directors preferred to directly distribute electronic surveys using general (i.e., untraced) links, and some organizations used paper surveys, and in both instances the total number of distributed surveys was unknown. Anecdotally, low participation rates across respondent groups were observed.

Outcomes cannot confidently be attributed to recovery coaching in the absence of a robust comparison group. In general, organizations did not have viable comparison groups as those seeking recovery treatment typically worked with recovery coaches as part of their treatment plan. Only four of the eleven organizations in this evaluation had at least one comparison group survey, and over half of the comparison surveys came from a single organization, further limiting the generalizability of any findings. Any analyses of program participants' outcomes cannot be attributed to recovery coaching in the absence of comparison observations.

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

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 for organizations with FY 2020 AmeriCorps-supported projects, but data collection remained challenging with only one focus group with program participants conducted during the May 2022–June 2022 data collection period. Virtual site visit options remained available for all organizations throughout the evaluation.

Recovery Coaching Programs

This chapter describes the recovery coaching models and the activities and services provided by the organizations. It describes the process for recruiting and training recovery coaches, and the processes for monitoring and tracking recovery coaches and program participants. It also documents partnerships that may exist to fill in programmatic gaps and describes how resources are leveraged to support the programs.

Recovery Coaching Models

While the 11 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 recovery coaching support model. To varying extents, recovery programming includes lived experience, cultural competence, holistic care, and harm-reduction practices. Following is a description of the key components of the recovery coaching models, beginning with the participants being served.

Participants Served

While all organizations served individuals with SUDs, the specific populations of focus varied greatly across organizations and across sites (for organizations with multiple sites). For example, organizations served individuals experiencing homelessness, veterans, survivors of commercial sexual exploitation, those formerly incarcerated, or those receiving treatment in an emergency department. Each organization's population of focus is detailed in exhibit 2-2. Organizations were varied in how they established their target population, but in general they sought to address gaps and needs; for example, a student group identified a need for more concrete support for college students in recovery. Another organization served a region with high stigma around substance use and sought to fill a need for support in this area for people with SUDs. In summary, this study's organizations serve diverse, high-risk communities across geographical regions of the country and provide a glimpse into the potential breadth of populations and areas reached by AmeriCorps-supported recovery coaching programs.

Role of AmeriCorps Members or VISTAs Across Organizations

AmeriCorps members and VISTAs supported recovery coaching programs in various ways, sometimes as recovery coaches themselves. Of the 11 organizations that participated in the study, 7 organizations were AmeriCorps State and National grantees and 4 were AmeriCorps VISTA sponsors. Across these 11 organizations, AmeriCorps members and VISTAs operated in a variety of roles and capacities to support their organizations' missions, which were summarized in exhibit 2-2.

Of the seven AmeriCorps State and National grantees, the majority (N = 5) had members providing recovery coaching services to program participants. For one organization, members delivered similar recovery support services and received the same training as the organization's coaches who were paid employees. In addition to recovery coaching, one organization helped to leverage its AmeriCorps members by engaging them in service projects that increased support for and connection with surrounding communities. The two AmeriCorps State and National grantees that did not have members providing recovery coaching enlisted members for other roles such as case management, opioid education and naloxone distribution, therapeutic counseling, and community education. Recovery coaching services provided at these organizations were provided by other individuals with lived experience. For one organization, AmeriCorps members lived in residential housing with program participants and facilitated weekly community nights.

VISTAs across the four AmeriCorps VISTA sponsor organizations did not provide recovery coaching services to program participants. VISTAs largely supported capacity building- and management-related tasks for the

recovery programs or other initiatives throughout the organizations. For two organizations, VISTAs supported project management and capacity building services related to housing and employment, community outreach, and education or recovery coach development. One organization had several VISTAs, each with separate specific roles; one role was directly related to recovery coaching while other roles centered on social media and health programming. For one organization, some VISTAs supported other initiatives provided by the organization such as youth programming, which was unrelated to recovery programming.

Organizations used AmeriCorps members and VISTAs to enhance organizational capacity and service provision to participants. AmeriCorps members at one organization helped with direct services to clients (e.g., answering the service line that the participants call with any requests), community education, and membership coordination. One AmeriCorps member assisted with a 5-hour financial literacy class for program participants. Another organization had AmeriCorps VISTAs who provided a variety of services. Services included 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 the organization for their practicum, and compliance tasks (e.g., contract requirements and documentation). The organization's AmeriCorps VISTAs also worked in the food pantry and garden. This organization had a lead AmeriCorps VISTA who managed the work of the other AmeriCorps VISTAs in the organization.

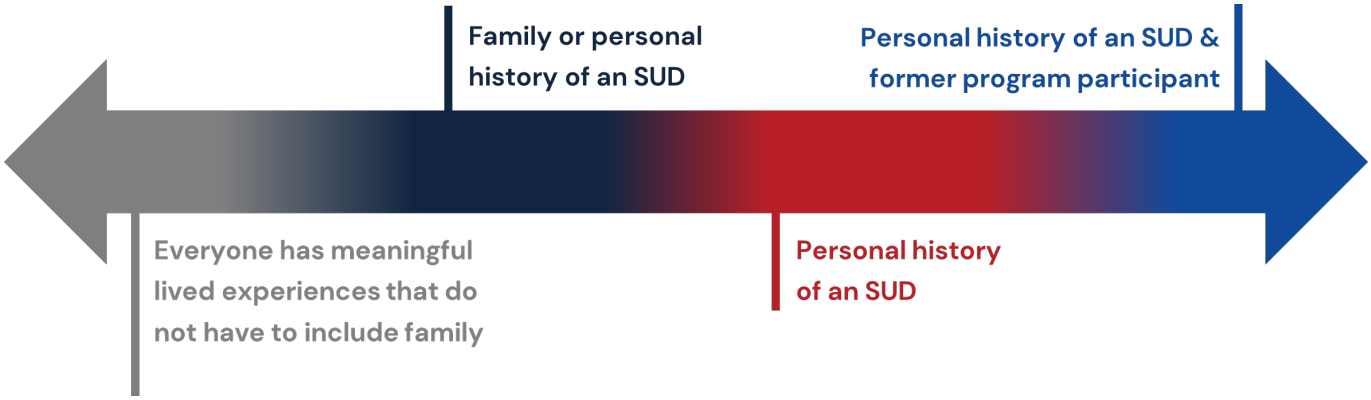
In summary, AmeriCorps State and National members and VISTAs were varied in their involvement with recovery coaching services; some were recovery coaches, and others provided auxiliary support throughout the organizations. Some organizations reserve (or at least prioritize) direct recovery coaching roles for members and VISTAs with lived experience.

Lived Experience

Lived experience was widely perceived as a key pillar of all organizations' recovery coaching models. However, the definition of "lived experience" within recovery coaching varied across organizations. Organizations' varying definitions of lived experience are depicted in exhibit 3-1. Some organizations had more specific, concrete definitions that they operationalized into their coaching models (e.g., coaches must be in recovery and an alumni of the program), while other organizations' definitions were less formal. Sometimes, program participants shared their own definition of "lived experience" that did not always align with the organization's definition. Organizations' definitions highlighted a continuum ranging from the broad idea that "everyone is in recovery from something" and thus has lived experience in their own ways regardless of SUD history, to the more specific idea that a personal experience with an SUD and/or family history of SUDs is needed, to the personal experience also including experience with the organization's recovery program.

> *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

EXHIBIT 3-1.—Continuum of lived experience as defined by participating organizations



Note: SUD = Substance use disorder.

Ten organizations had recovery coaches and individuals in the process of getting certified as recovery coaches with lived experience with an SUD and one recovery coach described themself as in mental health recovery, not substance use recovery. The remaining organization had a mix of coaches with lived experience and those without it.

Participants often noted the importance of lived experience for recovery coaches. A director noted that lived experience was the most important qualification for recovery coaches and they would not hire a coach who was not in recovery.

> *It's like someone who has diabetes. … You can read about diabetes in a book … but if you do not have diabetes, can you really tell me how it feels? … It's the same with addiction; if you lived that, you know that pain. It's real, you didn't read about it, you've actual felt it so it's genuine.*
>
> Program participant

Recovery coaches' lived experience was widely described as a critical ingredient of the success that helped to establish trust, hope, empathy, and relationship building between recovery coaches and program participants. Recovery coaches shared that having lived experience helped them in their work. Recovery coaches with lived experience with an SUD—unlike many other providers in the recovery community (e.g., social worker, case manager)—have intimate knowledge from personal experience struggling with an SUD and can connect to program participants through this shared understanding. This personal connection gives them the ability to foster a space in which program participants feel deeply seen and respected, with a lack of judgment or stigma, and which leads to greater comfort expressing themselves. One recovery coach noted that active addiction is "a very lonely place," so lived experience makes shared communication and greater progress possible. Several program participants echoed this sentiment, sharing that working with someone who has never "been in their shoes" makes it hard to open up

A Note on Terminology

While participating organizations had varying definitions of "lived experience," lived experience in the context of findings included in this report refers to individuals with either a personal experience with SUDs and/or family member(s) with SUDs.

due to fear of judgement. An AmeriCorps alum from one organization shared the importance of the relatability of recovery coaches:

> *I believe relatability is the entire point of being a peer supporter. That is exactly what you're supposed to do. You're supposed to meet people where they are and be able to say, "I was there." With your own experience, share with them things that you know, share with them the ways in which they could improve their lives, and help them navigate through the different ways so they can find the things that work for them. So, like I said, the relatability is the entire point.*

> *[Recovery coaches] use the worst of their experiences and they incorporate that into the success of their positive attributes. They enhance a [program participant] through foresight and knowledge from their own experience, like human resources. They're the ultimate human resources.*
>
> Program participant

Other interviewees stated that recovery coaches' lived experiences provide inspiration for others in recovery. Program participants from one organization explained the inspiration they felt knowing what their recovery coach had experienced and overcome (including relapses) and how this was a positive influence in believing they could also succeed. A program participant from one organization described how they are more likely to be honest with a recovery coach due to the trust and rapport their shared lived experience establishes:

> *There were times when I've had therapists or counselors and I shared how I felt, [I] poured my heart out and they give me the typical "Oh yeah" head nod. With the [recovery coach] I've done the same thing, made myself vulnerable, and they in turn made themselves vulnerable too. There's more of a connection than I would typically get with somebody who is not a [recovery coach]. … Like I am putting my experience out there and they can empathize with me. They understand because they've been there, they know.*

Some organizations described the intersectionality of different types of lived experiences as program participants were often coping with multiple co-occurring personal challenges. Intersectionality recognizes the complex relationship of various aspects of an individual's identity and lived experiences (e.g., mental health issues, SUDs, experiences with homelessness, commercial sexual exploitation, parenthood). This intersectionality reinforces the importance of organizations providing holistic services and using community partnerships to ensure program participants are receiving services that align with a multitude of cross-cutting challenges they may be facing. To accommodate the cross-cutting issues faced by program participants, one organization required their recovery coaches to have lived experience with both commercial sexual exploitation and substance use. While recovery coaches from another organization had lived experience struggling with SUDs, a program participant noted that they wished their recovery coaches would have had multiple types of lived experience (e.g., SUD and parenthood) as that this would have made them more relatable.

> *You're having a conversation and culturally, linguistically, we don't want to miss anything and that's one of the pitfalls. If you're not culturally competent, you're going to miss something.*
>
> Project director

Survey respondents expressed the importance of lived experience. All but one project director reported that having lived experience being in recovery was "very important" for recovery coaches. The one exception reported that lived experience for coaches was "very unimportant," introducing a distinct polarity from the majority. A little over half of the recovery coaches (65 percent) reported their own lived experience motivated them to become a recovery coach.

Culturally Appropriate Services

Nine organizations provide culturally appropriate services to their participants. When asked how organizations ensure their services are culturally appropriate, staff from three organizations said that they ensure their staff, including recovery coaches, are racially/ethnically diverse and reflect the communities of, and languages spoken by, their participants. Five organizations stated that they provide continuing education for program staff to promote the use of culturally appropriate styles of interaction and culturally appropriate language, particularly when working with historically marginalized groups (e.g., individuals that identify as LGBTQIA2S+,[2] Hispanic/Latino, etc.). Two organizations provided a faith- or Christianity-centered approach to their recovery services. When asked about the extent to which they made accommodations for non-religious participants or participants of another faith, one organization shared that the program was tailored to accommodate the participants' religious beliefs as needed. Two organizations noted the importance of training staff, including recovery coaches, on the provision of culturally responsive services to program participants. A project director shared:

> *[City] is a very diverse community, and we ensure that [the organization] puts in our curriculum several training sessions that address cultural competency, like LGBTQ cultural competency … and we have other training where we encourage [recovery coaches] to have an open mind when it comes to meeting people with different cultural ethnic backgrounds. We always emphasize providing a client-centered approach; that means they have to listen to the client's concerns [and] values, instead of trying to bring an agenda.*

Even so, participants from one organization shared there are always areas for improvement related to increasing the cultural awareness and responsiveness of the organization.

The programs offer employees and program participants culturally responsive treatment environments. Ninety percent of project directors reported that their organizations reflect a culturally responsive treatment environment. These areas include evaluation and monitoring (85 percent), client treatment planning (80 percent), organizational infrastructure (75 percent), and workforce and staff development (90 percent). Only 50 percent of project director respondents reported culturally responsive environments for governance and 40 percent reported language service. It was unclear if the relatively infrequent endorsement of language services reflects an unmet need or whether the lack of language services is due to lack of need among the program participants.

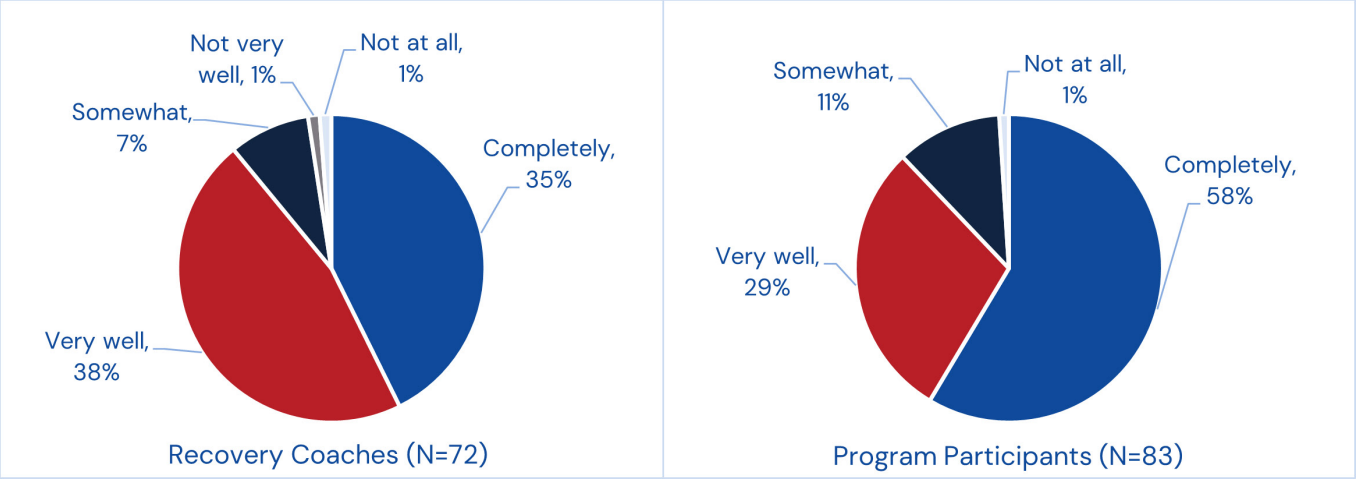
Project directors also reported on the incorporation of various client characteristics, beliefs, and concerns into treatment plans. The least endorsed component incorporated into treatment approaches were clients' English, bilingual, or multilingual fluency (50 percent) and treatment concerns related to cultural differences (50 percent). The most endorsed components (each reported by 85 percent of project directors) included family and extended family concerns; beliefs about substance use, abuse, and dependence; beliefs about substance abuse treatment; work history and concerns; and community concerns. Only 55 percent of respondents

[2] Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Asexual, and Two Spirits is LGBTQIA2S+.

reported including sexual orientation and gender identity or cultural approaches to healing or treatment of substance use and mental disorders.

Program participants and coaches were asked the degree to which the organization's services reflect their culture and worldview. Eighty-seven percent of program participants and 72 percent of coaches responded "completely" or "very well," generally demonstrating perceived alignment of culture and worldview with the services of the organization (see exhibit 3-2).

EXHIBIT 3-2.—Perceptions of culturally appropriate treatment plans



Sources: Recovery Coach Survey: "The treatment plans I develop with my clients reflect their culture and worldviews" and Program Participant Survey: "My treatment plan reflects my culture and worldview."
Note: Thirteen of the seventy-two recovery coaches and one of the eighty-three program participants did not answer this question.

Holistic and Person-Centered Services

Holistic care is a common recovery program component across organizations. All 11 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 approach to recovery. Interviewees expressed that it is important to "care for the whole person" to maintain recovery. These comments from project directors exemplify the importance of holistic care in recovery coaching:

> *If someone is coming out of addiction, the healthier they get, the less likely they are to fall back into their old lifestyle. The more community that we build, the better their chances are as well. We're just really trying to build relationships from every angle that you could possibly imagine.*

> *People who have matriculated through our program [are] now being employed [by the organization]. … Because you can abstain from using drugs and alcohol. You can go to meetings, but if you*

> *We don't want to only address the symptoms; we try to investigate [the] underlying conditions that can put that person in that situation. If you only treat the symptoms, the substance misuse, [and] don't investigate further what other issues [the] person is dealing with, your intervention will be very limited and most likely unsuccessful.*
>
> Project director

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

still have a mental health concern or a family concern, financial concern—more than likely you haven't recovered [from] all pieces of your life.

Holistic care also acknowledges the different needs program participants have on their path to recovery and the need to provide individualized care. Specifically, participants from two organizations noted that within the program, all participants have their own individualized treatment plan and goals, as all participants have differing experiences and needs. This holistic care entails a variety of in-house services and referrals for services such as financial, housing, employment, and mental health support, as described in the next section. All organizations provide participants with personalized referrals and services.

Harm-Reduction Strategies and Services

Organizations must consider state restrictions around needle programs. **Ten organizations include harm-reduction strategies as part of the program.**[3] That said, not all organizations specifically used the term "harm reduction" to describe the in-house programming they engage in—or have partners that engage in—even when those practices fall under that umbrella. These practices include providing Narcan, fentanyl testing strips, medication-assisted treatment, medication disposal bags, and needle exchanges to program participants. Two of the organizations had partnerships with harm reduction or methadone clinics to which recovery coaches could refer program participants.

> *Personally, I had a hard time quitting cold turkey. So, it's been helpful to try to workshop it with [my recovery coach] who can see what I've done. It's helpful to have someone there whose like, 'No, you are making progress,' because a lot of times it feels like I am not.*
>
> Program participant

Additionally, one organization had a component of their recovery coaching model related to safe- and managed-use. One organization shared that in the past couple of years, their organization had been striving to promote a "harm-reduction culture" and seeks to welcome program participants to connect them with the appropriate harm-reduction strategies. Recovery coaches from the organization explained their role in working with clients to support safe- and managed-use because "peer work and harm reduction need to go hand in hand." As a representative from that organization explained:

> *If there is somebody involved in our program who is practicing harm reduction as opposed to just abstinence, we really try to hook them in with a coach, just to have someone to check in with throughout that process. Making sure that they are hooked in with outside organizations that provide like more harm-reduction targeted services. Whether it be getting them hooked into needle exchange, health brigade, or making sure that they always have Narcan, or you know, giving them a list of say, these are safe using practices, things like that.*

[3] 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."

Three organizations described "meeting [program participants] where they are" rather than shaming program participants for substance use. One organization updated their community guidelines so that if a program participant tested positive for a substance, they were not immediately asked to leave the program and lose housing. Instead of creating a culture of fear and shame after a relapse, the program sought to foster an environment where program participants were comfortable sharing their struggles so they could be connected to the most relevant resources.

> *[A program participant] was able to go to an AmeriCorps member and say, 'Hey, I used.' … That's what we want! That is huge; [they] feel safe enough to tell [them] that, then we can help [them].*
>
> Project director

Two organizations had AmeriCorps members utilizing harm-reduction strategies as well, such as receiving Narcan training and certification. Additional harm-reduction strategies and programs include confidential and at-home HIV and hepatitis C testing and treatment and Neonatal Abstinence Syndrome harm-reduction programming and treatment. While one organization was not actively using any harm-reduction strategies, participants shared that they had received training that included information on safer and managed use of substances.

Additional Activities, Services, and Referrals to Partner Organizations

Directors, program participants, recovery coaches, and AmeriCorps members discussed a wide range of services and partnerships that are not directly recovery-related during the site visits. For all organizations, the provision of additional services is part of the holistic care model that treats the whole person in recovery. This section describes the range of additional activities and services facilitated by the organizations and the leveraging of AmeriCorps members and VISTAs to provide additional services, and the use of partnerships to administer activities and services.

> *It's important for us to have relationships in the community where we can send individuals that are in immediate need for services to. You have a small window to help people and we try to make sure that we work within the time that they're here.*
>
> Project director

Nine organizations worked with partner organizations and/or providers in the 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).

Five organizations worked with organizations to provide participants with alcohol and drug treatment and detox centers and medically assisted treatment. While participants from one organization remarked that they maintained over 100 linkage agreements for services such as food, clothing, housing assistance, and furniture, most were for medical services for individuals who relapsed or were seeking detox services. Due to the limited capacity of some organizations, referrals to other SUD treatment programs helped to ensure everyone received adequate support. One organization partners with several organizations including in-patient programs that 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. Similarly, a different organization has 121 referral partners, including counseling services and workforce partners.

Three organizations discussed health-related partnerships made available to their participants. Partnerships with United Healthcare and Truman Behavioral Health address the physical and mental health needs of participants at one organization. At another organization, new and expecting mothers can fulfill their required twice-weekly therapy sessions through a partnership with Women's Health Innovations or Catholic Charities. This same organization also has an evaluation partnership with Mathematica. At one of the sites of a multisite organization, staff have a partnership with the Virginia Commonwealth University Counseling Service that allows recovery coaches to give a warm hand-off to licensed therapists, which makes the process easier for participants.

Three organizations spoke about the resource lists they make available to program participants. These include both local and state resources that program participants can access. A former AmeriCorps member from one organization noted the resource list was a helpful tool when discussing available supports and resources with program participants.

> *I go into areas where there is a high level of addiction and talk to peers. Give them recovery information about [the organization] and all the resources that can help. I go to different probation and parole offices, hospitals, and churches, and just talk and socialize to give them my experience, hope, and how recovery helped me; so, hopefully it helps someone else.*
>
> Recovery coach

Partner organizations improve education attainment for participants. Two organizations discussed partners providing enrichment classes for program participants such as General Education Development (GED) courses.

Program staff from two organizations described the importance of partnering with organizations that provide job readiness training and individual career coaching to individuals in recovery from an SUD. One such partnership helps connect job-seekers in recovery with job opportunities and essential resources such as cell phones. This organization also runs a community resource center that helps provide program participants with basic needs services and a re-entry program as well as a drop-in center, through partnerships with other community organizations.

Four organizations had difficulty collaborating with or finding partners. Two organizations cited stigma around substance use or around other characteristics of their service population (e.g., human trafficking victims) that limited partnerships, and therefore limited the additional activities and services they could provide to clients. A former AmeriCorps alum explained that when they would call partners to advocate for the program participants, they felt they were met with discrimination and judgement from partners:

> *I called one agency and I'll never forget, but I called requesting information for a program. I was talked down to so poorly. But when I said I am not the person looking for help, I am just calling for information, their tone changed.*

Across all 11 organizations, the provision of additional services is part of the holistic care model that treats the whole person in recovery. For example, one organization 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 provides examples of in-house and referral services across organizations and while this list is not exhaustive, it illustrates the range of holistic care supported.

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

Organization	Examples of Referrals and Other Services Provided			
Above and Beyond (AnB)	• Acupuncture • Art therapy	• Employment services • Housing services	• Trauma therapy • Yoga	• Dance • Life skills classes
Align9	• Transportation assistance • Childcare	• Employment services • State ID	• Mental health counseling • Family reunification	• Medically assisted treatment
County of Washington	• Testing (HIV, etc.) • Legal services	• Health clinics (immunizations) • Basic provisions	• Transportation assistance • Housing	• Food pantry • Case management
Covenant Community	• Transportation assistance • Documentation	• Computer access • Health checkups	• Stabilized housing • Employment	• Therapeutic programs • Food
Footprints	• Health checkups • Food	• Counseling • In-patient care	• Emergency shelter • Education	• Medically assisted treatment
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	• Free legal services • Relocation services	• Gathering spaces • Washroom
Maggie's Place	• Counseling • Clothing	• Transportation • Basic provisions	• Housing • Family reunification	• Child supplies • Food pantry
NYC Department of Health and Mental Hygiene	• Documentation • Clothes	• Basic provisions • Testing	• Mental health treatment • Housing	• Detox • Employment
Recovery Corps	• Social services • Testing (HIV, etc.)	• Food • Transportation assistance	• Education services • Health clinics	• In-patient care • Clothing
RHOPE	• Case management • Counseling	• Social services • Clothing • Food	• Medical appointments • Detox centers	• Choir • Faith services • Clinicians

Adapting Activities and Services During the COVID-19 Pandemic

Organizations had to be flexible due to the pandemic.[4] Three organizations had to temporarily discontinue various in-person services. One organization's services were deemed essential, so they remained open throughout 2020 and 2021. The 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.

> *If we could get everybody in one room and brainstorm how can we help each other. I feel like sometimes people are on this little island doing their own thing.*
>
> Partner organization

The organizations put substantial effort toward providing services and connecting program participants to resources, despite hurdles during the pandemic. Two organizations 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 organizations serve were affected by diminished in-person services and resources, particularly at the height of the pandemic.

To make virtual services possible, organizations had to procure special grants to provide program participants with computers, tablets, phones, or Wi-Fi hotspots. One organization obtained a grant to provide prepaid cell phones to participants. Organization staff had to provide technical support, and some did not always have the capacity to assist. While recognizing the benefits and importance of virtual services, some organizations worried that virtual services were not as effective as in-person services, 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 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 organizations have moved overhead processes, such as training and onboarding, to online versions, and they plan to continue to provide these virtually. Some organization staff will remain remote.

Recovery Coach Identification and Recruitment

Many recovery coaches who completed the survey were working full-time at their organization (79 percent). The average self-reported tenure of recovery coaches was relatively short—most recovery coaches (60 percent) have served their organization for less than 1 year—and the remainder of coaches (35 percent) have been at their organization 1–5 years (with N = 4 coaches not responding to this survey question).

Organizations use multiple methods to identify and recruit potential recovery coaches. Seven organizations reported that they exclusively or often recruit recovery coaches from their own programs (i.e.,

[4] Data collection for four organizations occurred in spring 2022 when various restrictions were in place due to the pandemic. These four organizations shared ways the pandemic influenced their recovery coaching programming. While other organizations may have experienced similar successes and challenges, subsequent data collection that occurred in fall 2023 did not include discussions of COVID-19 and are thus not included in this section.

program graduates or "alumni").[5, 6] One organization has not needed to advertise for their recovery coach positions because they have filled all openings internally. Four organizations recruit from community recovery programs and trainings, other community organizations, and schools and universities. A project director explained that as one of the state trainers for the state's recovery coaching certification, they were able to meet and recruit eligible recovery coaches. Two organizations often use job websites and online platforms of recovery networks (including peer-support and trafficking survivor networks) to post recovery coach positions. Alternatively, one organization hosted an "open house" for prospective coaches and then opened the recruitment to a formal application process for interested parties.

Recovery coach responses to the survey item, "I am certified by the state where I work":

- 42 percent are certified
- 36 percent are not certified
- 7 percent said "other"
- No data for 15 percent of coaches

According to one director, it takes a special type of person to become 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. Project directors from two organizations mentioned that the ability to set boundaries as a recovery coach was a key skill that ensures the relationship between a recovery coach and a participant remains professional. One project director articulated why boundary setting is so important for recovery coaches:

> *Once the chemicals are removed, the individual is there. So now we deal with the trauma piece … and [recovery coaches] need to know where that line stops as [recovery coaches], and when I am going to have to do a hand-off to [a mental health clinician] … so that makes a difference in terms of setting boundaries … be empathetic, understanding, yes, but you got to stay professional. You can't get too friendly because that can also be perceived not necessarily the way you intend it to.*

Project directors from three organizations also believed that computer skills were important. Lastly, project directors from two organizations stated the ability to set and manage expectations was essential to client relationships.

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

Hiring requirements differed across organizations. Ten organizations required that recovery coaches were certified or in the process of getting certified in order to serve as recovery coaches. Two organizations noted that recovery coaches did not need to be certified before being hired; however, they did require recovery coaches to be working toward their certification after they were hired. One organization does not require their recovery

[5] One organization was a collection of sites across the state; while only one of the three sites included in the study noted that they hire a lot of program graduates as peer recovery coaches, the organization is included in the total count.
[6] One organization had a mix of recovery coaches with personal lived experience (i.e., peer recovery coaches) and others with family with an SUD (i.e., recovery coaches). Site visit participants described that peer recovery coaches were recruited from the program; however, it was unclear how recovery coaches were recruited.

coaches to be certified, but still promoted certification and offered to pay for recovery coaches to obtain their state certifications.

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. In addition to certification requirements, organizations placed requirements or suggestions for periods of sustained recovery for recovery coaches. Three organizations required 1 year of sustained recovery while three others required 2 years. One organization did not provide a specific amount of required time but reported that recovery coaches "have to be sober for a while," suggesting some degree of sustained recovery is observed in hiring practices. Alternatively, a project director from one organization described their program to be "vocational" and did not require recovery coaches to receive a certification as they did not want to "exclude people who want to empower themselves" and acknowledged the time and financial requirements of receiving a certification. Instead, recovery coaches were encouraged to have lived experience with substance misuse.

Challenges in Recruitment and Hiring

Organizations identified the criminal history background check as one barrier to hiring recovery coaches. Four project directors noted that failing the background check can be a problem when hiring recovery coaches, especially when background checks are included as part of the certification requirements. They said that if you want to encourage programs with lived experience, lived experience comes with challenging backgrounds and one might expect a certain level of involvement with the justice system. One organization estimated that about 95 percent of their recovery coaches have been involved with the criminal justice system. The organization wants to make sure that all members who can serve are able to serve and that organization's compliance team spends significant time on background checks. According to the project director, any program that has a lived experience component needs someone who can speak from direct experience:

> *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 organization 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 obtain skills when it proves challenging to find other employment due to criminal history background checks. One organization expressed dissatisfaction with the vendor that was used for the background checks. The vendor did not provide transparency as to why a member who was otherwise favorably considered for hire by the organization could not be cleared. 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 his application included dozens of letters of support attesting to his character. Due to situations like this, one director recommended an appeals process might be warranted for the AmeriCorps background check process.

AmeriCorps service members' stipend is a reported barrier to hiring and retaining recovery coaches. Only half of the project directors agreed or strongly agreed that the member stipend is sufficient, while 22 percent disagreed or strongly disagreed, and the remaining 28 percent were ambivalent. 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 and partner organizations during site visits. Two members noted that one cannot afford to live on their own and be an AmeriCorps VISTA because of the limited stipend amount. One recovery coach remarked that they cannot afford to stay with AmeriCorps because they need to make more money. Similarly, partners from one organization mentioned that the amount of the AmeriCorps stipend was relatively low, which contributed to challenges with retaining AmeriCorps members. Among the AmeriCorps members who provided recovery coaching, despite the progress made toward the professionalization of recovery coaching in recent years, low stipends were described as a barrier.

Certification and Training

The requirements for certification as a recovery coach vary by state and not all organizations require recovery coaches to be certified. Recovery coaching certifications are relatively new, and requirements continue to evolve as the SUD recovery space also continues to change. Not all organizations that participated in the study required that recovery coaches be certified. Participants from one organization described certification in their state as having some of the most stringent requirements for recovery coaches. The certification process includes several tests and a full year of training and internships, with some exceptions for people with lived experience. Participants from another organization said their state requires that peer support specialists complete 46 hours (5 days) of training and 475 hours (about 3 weeks) of service to be certified. At another organization, participants described that in their state, 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. Several states have different levels of certification depending on the individuals' level of lived experience with SUDs and/or the duration of work experience and supervised practical experience. Recovery coaching certifications and requirements are relatively new and evolving as the field continues to seek to become more professionalized. Exhibit 3-4 includes a high-level summary of recovery certification requirements for organizations' that participated in the study, and it is based on the study team's review of relevant government websites and is not intended to be exhaustive. Not all organizations that participated in the study required that recovery coaches be certified.

EXHIBIT 3-4.—State certification requirements

State	Certification	Minimum Education Required	Personal Recovery Required	Exam Required	Hours of Training/ Education	Hours of Work Experience	Hours of Supervised Practical Experience
Arizona[1]	Certified Peer Recovery Specialist (CPRS)	High school diploma or GED	No	Successful score on the IC&RC Peer Recovery Exam	46 clock hours	500 clock hours supervised	25 clock hours of supervision
Georgia[2]	Certified Peer Specialist Addictive Disease (CPS-AD)	High school diploma or GED	Yes: 1 year	Unknown	Unknown	Unknown	Unknown
Illinois[3]	Certified Peer Recovery Specialist (CPRS)	High school diploma or GED	Yes: 2 years	Successful score on the 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

State	Certification	Minimum Education Required	Personal Recovery Required	Exam Required	Hours of Training/ Education	Hours of Work Experience	Hours of Supervised Practical Experience
Minnesota[4]	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[5]	Certified Peer Specialist (CPS)	High school diploma or GED	Yes	Passing score on the CPS Online Exam	35 clock hours (week-long training course)	N/A	N/A
	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 experience within the last 10 years	25 hours of peer supervision in the IC&RC peer recovery domains
	Missouri Recovery Support Specialist (MRSS)	High school diploma or GED	No	N/A	3-day training program	1,000 hours of applicable experience within the last 10 years	N/A

State	Certification	Minimum Education Required	Personal Recovery Required	Exam Required	Hours of Training/ Education	Hours of Work Experience	Hours of Supervised Practical Experience
Nevada[6]	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 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
New York[7]	Certified Addiction Recovery Coach (CARC)	High school diploma or GED	No	Passing score on ASAP-NYCB Recovery Coach Exam	60 clock hours	N/A	N/A
	Certified Recovery Peer Advocate (CRPA)	High school diploma or GED	No	Passing score on IC&RC Peer Recovery Exam	50 clock hours	500 hours role experience	25 clock hours of being mentored/ supervised
Ohio[8]	Peer Recovery Supporter (PRS)	High school diploma or GED	Yes	Passing score on Ohio Peer Recovery Supporter Certification Exam	40 clock hours or have 3+ years formal experience	N/A	N/A
Tennessee[9]	Certified Peer Recovery Specialist (CPRS)	N/A	Yes: 2 years	N/A	40 clock hour training	N/A	N/A

State	Certification	Minimum Education Required	Personal Recovery Required	Exam Required	Hours of Training/ Education	Hours of Work Experience	Hours of Supervised Practical Experience
Virgina[10]	Certified Peer Recovery Specialist (CPRS)	High school diploma or GED	Yes	Passing score on IC&RC Peer Recovery Exam	72 clock hours DBHDS CPRS training	500 hours of experience specific to peer recovery services	25 clock hours of on-the-job supervision

[1] Arizona Board for the Certification of Addiction Counselors

[2] Georgia Department of Behavioral Health and Developmental Disabilities: Certified Peer Specialists

[3] Illinois Certification Board: Professional Certification

[4] Minnesota Certification Board: Peer Recovery

[5] Missouri Credentialing Board: MCB Credentials

[6] Nevada Certification Board: Peer Recovery Support Specialist

[7] New York Certification Board

[8] Ohio Department of Mental Health & Addiction Services: Become a Family Peer Supporter

[9] Department of Mental Health & Substance Abuse Services: Certified Peer Recovery Specialist Program

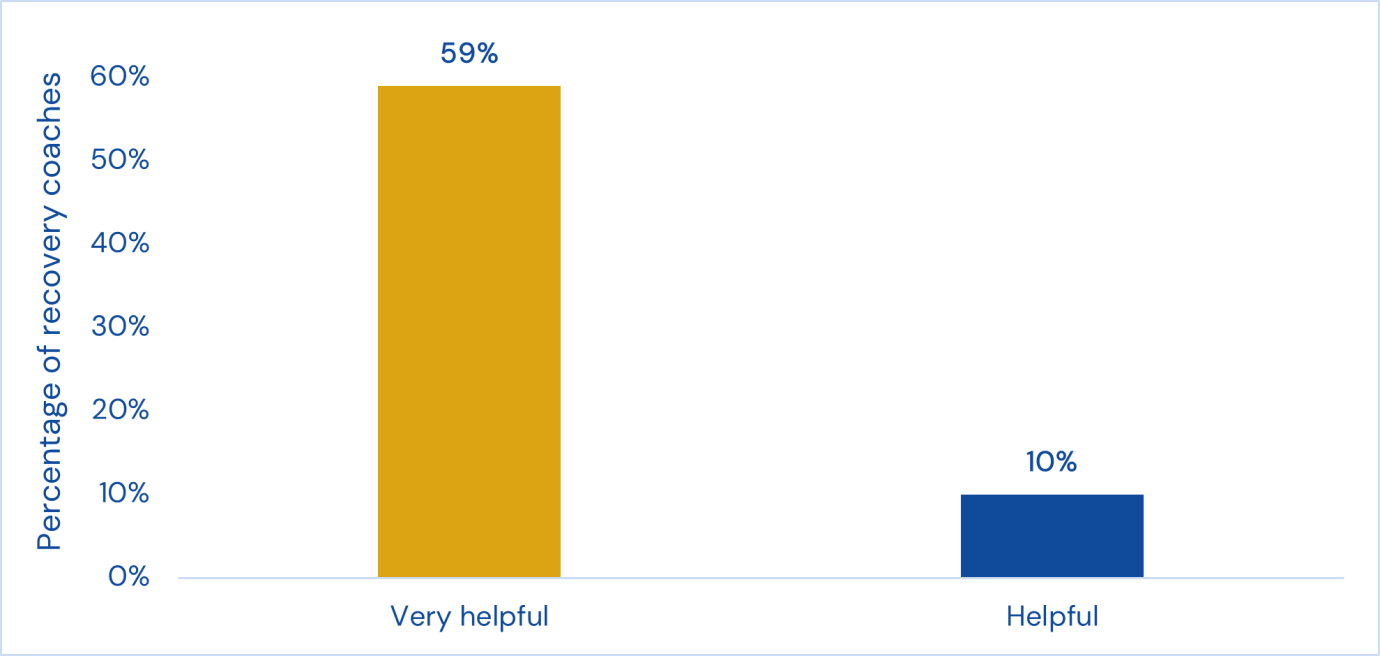
[10] Virginia Certification Board: Certified Peer Recovery Specialist

Organizations also require organization-specific training for recovery coaches and other staff. Ninety percent of project director survey respondents reported that they have an onboarding process for recovery coaches that may include supervision policies and required training. Six organizations require organization-specific training during onboarding in addition to the AmeriCorps training and the state recovery coach certification. One organization 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 organization 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.

Partnerships provide supplemental training for recovery coaches. Three organizations offer training at local colleges for topics such as suicide prevention certification, assessing suicidal ideations, and resiliency training. Another organization received free opioid training and naloxone from a local project called Missouri Opioid-Heroin Overdose Prevention and Education.

Recovery coach survey respondents were asked a series of questions about the training they received. Thirty-eight percent of recovery coaches reported that they received 9–16 hours of training and 32 percent reported 17 or more hours of recovery coach training. Six percent reported not receiving any training. The training programs tended to use a specific curriculum or manual (47 percent), usually the state curriculum or the organization's training manual. Training instructors could come from within or outside the organization; 39 percent of recovery coaches indicated that the training was conducted by someone within the organization and 36 percent reported an instructor from outside the organization. However, 25 percent didn't respond or responded with "don't know." As illustrated in exhibit 3-5, recovery coaches generally found the training helpful.

EXHIBIT 3-5.—Perceived Helpfulness of Trainings (N=72)



Source: Recovery Coach Survey: "How helpful was the training?" Fifteen of the 72 recovery coaches did not answer this question.

Program Monitoring and Tracking

Eighty-five percent of the director survey respondents reported that they have monitoring and oversight plans. Several interviewees discussed the heavy emotional burden and potential for burnout among recovery coaches. To combat this, four organizations spoke about their efforts to monitor the mental health of their coaches. Two organizations had regular check-ins with their recovery coaches to discuss self-care practices and vicarious trauma. They reported that this preventative method has been successful in addressing possible issues before they affect the recovery coach or their work more significantly. A project director mentioned they strive to establish a strong level of comfort and positive relationship with their coaches, so they feel comfortable expressing themselves when they need help or are struggling. Another organization 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 can be difficult for gauging the emotional state of a recovery coach. 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. Outside of check-ins with coaches, one organization noted they did random testing for recovery coaches to monitor and track staff substance use relapses, discussed in greater detail in the next section.

Staff Relapses

The surveys generally suggest that relapse is among a project director's considerations for their recovery coaches, but not unilaterally deterministic for the role of recovery coaching. Seventy-two percent of recovery coach participants self-reported being in long-term recovery and 70 percent of directors reported tracking relapses in their organizations' recovery coaches. Directors rated the importance of staff not relapsing in order to remain as recovery coaches; while 40 percent of directors did not respond to this question thereby limiting the interpretation of the findings, those who did respond reported it was "very important" or "important."

> *Relapse is part of recovery and it's certainly not the end of the world.*
>
> Project director

In the project director interviews, all organizations indicated that a 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, or a "restoration period," is given while the staff member focuses on their recovery. Due to the connections and partnerships organizations have, project directors shared they often refer staff who have relapsed to other treatment or recovery programs. Interviewees 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 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. Beyond access to treatment, one organization noted that if staff decide to return, recovery coaches had to "work towards [getting] some of their responsibilities back," which they had found to be a successful approach to re-engaging coaches.

> *We are a drug-free workplace, but we're recovery-friendly as well.*
>
> Project director

One organization has a relapse protocol for recovery coaches who are AmeriCorps members. According to the organization, the important thing is to remove the member from the site and to discuss the situation and

next steps. They discuss what caused the relapse and assess whether the member has broken any AmeriCorps rules. Next steps occur on a case-by-case situation, depending on the site and the member's willingness to make changes. However, not every organization has had a recovery coach relapse.

Program Participant Relapses and Overdoses Amidst COVID-19

Ninety percent of director survey respondents reported that they have a process to maintain contact with clients after they enter the program. Multiple organizations also reported that they had participants relapse, overdose, or die during the COVID-19 pandemic. Organizations attributed these relapses and deaths to the stress of the pandemic on participants, a lack of support due to isolation during COVID-19, and limitations beyond their control (e.g., COVID-19 restrictions requiring the closure of organizations' centers or modification of services). However, participants' reports of the pandemic's effects on their programs or program participants continually decreased as this study progressed and as the nation continued to experience fewer casualties and disruptions due to COVID-19.

Recovery Coaching

At the core of the recovery coaching programs are the individual recovery coaches who 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, including referrals to outside organizations. Next, reported successes and challenges associated with recovery coaching are highlighted. Finally, the reported reasons for becoming a recovery coach and organizations' supports for recovery coaches.

Recovery Coaching Support

During the site visits, organizations described different types of support they provided to program participants. These supports have been organized according to emotional supports, informational supports, affiliational supports, instrumental supports, and mental health supports.[7] The following includes a description of the various types of supports described by recovery coaches, program participants, and other program staff during interviews and focus groups. Survey data also provides detail on information supports offered by each organization.

Emotional Support

A key support is emotional support, by which a recovery coach listens to program participants, shows concern, and provides empathy in, for example, mentoring sessions or support groups. Recovery coaches and participants from all 11 organizations discussed examples of emotional support provided by coaches. At one organization, participants attend daily support groups and receive emotional support from other participants and recovery coaches. At another organization, recovery coaches often provide immediate support to participants by staying in frequent contact with participants using text messaging. At a third organization, participants do a group meeting and follow up with individual mentoring sessions with recovery coaches.

Emotional support consists of demonstrating empathy, caring, or concern to bolster someone's self-esteem and confidence (Center for Substance Abuse Treatment, 2009; SAMHSA 2017).

At least one or more recovery coaches from each organization expressed that their personal experience helps them to develop trust and to provide emotional support. A recovery coach noted participants are more likely to open up to someone who has shared lived experience in recovery. One recovery coach believes that seeing the progress of someone else with an SUD to becoming a recovery coach brings participants hope that they can make substantial progress too: "My life is a testimony." One recovery coach stated that they can empathize with feelings of low self-esteem and worthlessness. They try to be a resource for people in similar situations because many lack someone with whom to talk. In their opinion, as long as recovery coaches exhibit authenticity and empathy and make connections with program participants, the participants will

The peer model is not 'Let me do for you'—it's, 'Let me stand next to you and support you.'

Project director

[7] During thematic coding of interview and focus group data, recovery coaching supports described by each organization could be categorized as one or more type of support (i.e., each category of support is not mutually exclusive).

> *I let them know that they're worth something. Somewhere down the line, some of them lost themself. So, I am better at building them back up, building their character back up and self-esteem back up.*
>
> Recovery coach

continue to make positive changes. A participant at one organization shared that feeling free from judgement and receiving empathy plays a big part in their recovery.

Recovery coaches play a key role in helping participants to learn healthy coping mechanisms when experiencing challenging emotions, which can be crucial for maintaining recovery from SUDs. One recovery coach noted that they support participants by being present with them through physical and emotional pain. A recovery coach likened peer-to-peer interactions to "free therapy," which suggests recovery coaches can provide an outlet for challenges and experiences among program participants. A recovery coach described that they help participants by listening to them and talking through things with them rather than telling them what they are doing wrong or should be doing.

Recovery coaches believe it is important to give hope to those who need it most. One recovery coach said that showing genuine care and empathy as a coach brings participants hope, which many participants lack. Another recovery coach said that no matter how bad things get, there is "always a light at the end of the tunnel." They try to give that to others. One recovery coach emphasized the importance of helping participants build back their confidence and self-esteem and giving them the hope to get back up and start again.

Recovery coaches are also called upon by other staff at their respective organizations to provide emotional support that draws upon their lived experience with an SUD. One example was shared by an AmeriCorps member who also serves as a recovery coach. The recovery coach described a case manager was having a routine meeting with a participant and the participant was 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 their relationships were affected by SUDs, and how they had to put boundaries in place. The conversation about establishing boundaries was helpful to the participant and reinforced their recovery.

> *[My recovery coaches] try to guide me to … make better decisions and how to ask for help. Because I have an issue with asking for help, so they have to be able to build up that trust.*
>
> Program participant

Program participants described reaching out to contact their recovery coaches when they have the urge to use substances either via text, phone, or in-person. A participant shared that it was critical that their recovery coach was always there to support them on good days and on bad days, and on days when they want to use substances. One recovery coach stated that some of their participants have opioid prescriptions to manage pain, but they ensure that they carefully listen to participants' concerns and discuss different pathways to manage pain in a safe manner.

Informational Support

All organizations discussed the provision of various types of informational supports such as connecting participants to community resources as well as sharing knowledge and information that support health and wellness. Across organizations, these information

Informational supports include: connections to information to community resources that support health and wellness (Center for Substance Abuse Treatment, 2009; SAMHSA 2017).

supports included things such as detox centers, laundry and shower services, art therapy, counseling, and medical services. Recovery coaches at one organization provided information and resources to participants and the wider recovery community via a podcast and a website. One recovery coach stated that their typical day consists of online research to find resources in the area for program participants (e.g., treatment or detox centers). They also help with justice-involved participants by serving as a pen pal to those who are incarcerated to help connect them with recovery resources before they transition out of prison.

> *I have pamphlets for pretty much everything. … I have my wall of phone numbers of people that I connect with. I've yet to have a person ask me for something that I cannot find them a place for, except for an apartment.*
>
> Recovery coach

Another recovery coach discussed assisting program participants in their job search by developing resumes and helping them navigate job search websites. They 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 [job posting website] 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

Ten organizations provided examples of community supports, activities, and events (also known as affiliational support) that are made available to participants either within the organization or via referrals. Common affiliational supports include recovery-friendly social activities and events, spaces to gather at the organization, and resources about Narcotics Anonymous (NA) or Alcoholics Anonymous (AA). Many organizations have recovery-related support groups. These include an anger management group, grief and relationship-building groups, and a music and wellness group class. One recovery coach discussed the drug- and alcohol-free picnics and sports tournaments that participants and community members engage in through the organization. Similarly, recovery coaches and participants at one organization discussed the holiday parties and social events led by coaches such as bowling and "sip and paint" with juice instead of wine. A recovery coach described that they create 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

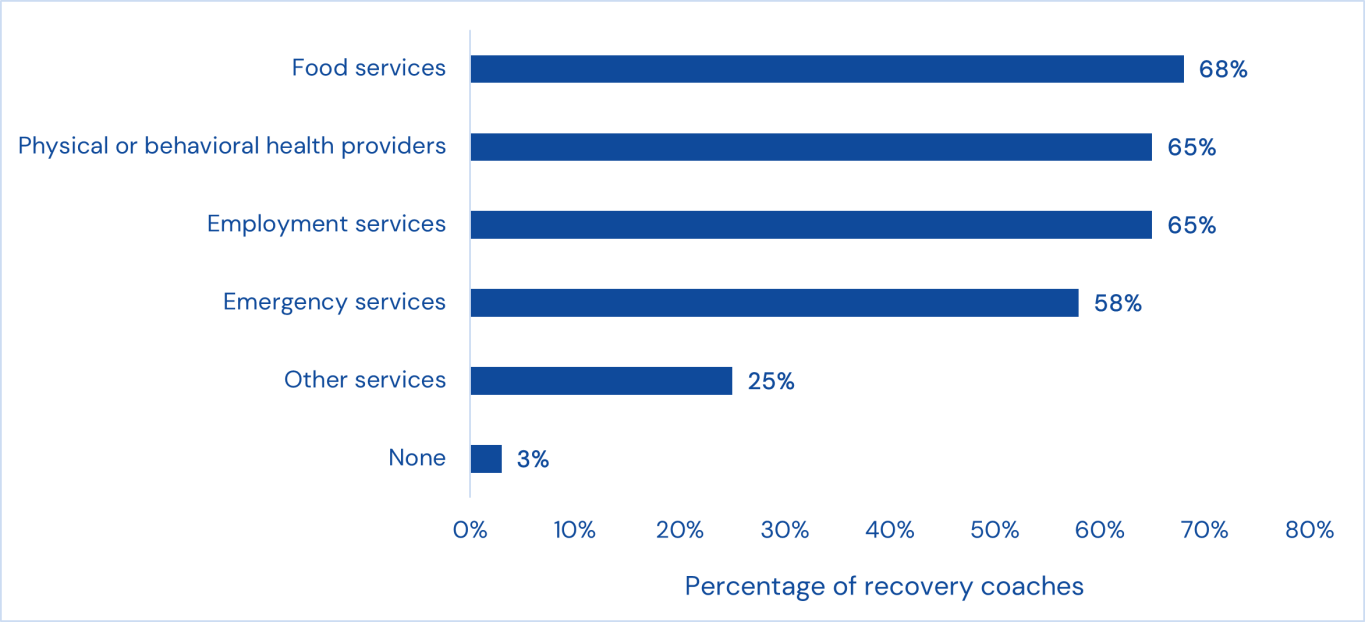
SAMHSA defines **affiliational support** as "contacts with other people to promote learning of social and recreational skills, create community, and acquire a sense of belonging" such as recovery-friendly activities and events (Center for Substance Abuse Treatment, 2009).

Instrumental Support

Instrumental supports include: referrals to services and concrete aid, such as filling out employment forms or obtaining basic need items.

Recovery coaches reported connecting their clients to various supports. Exhibit 4-1 illustrates the prevalence of coaches referring to each of these five supports: physical or behavioral health providers (65 percent); food services (68 percent); employment services (65 percent); emergency services (58 percent); other (25 percent), and none (3 percent).

EXHIBIT 4-1.—Referrals to outside services provided by recovery coaches (N=72)



Source: Recovery Coach Survey: "What other supports do you connect clients to?"

During interviews and focus groups, recovery coaches from all but one organization discussed the different concrete service referrals that they provide to program participants and how they help the participants navigate outside services. Recovery coaches provide referrals for housing, including emergency shelters, sober homes, and long-term housing. One recovery coach described that they have a "shelf full of resources" on housing and food pantries depending on where the participants are in the city. Other recovery coaches discussed referrals they make for counseling services, legal services, and employment.

> *[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

Recovery coaches also provide tangible services. For example, a recovery coach talked about their time as a program participant at their organization and receiving help furnishing their apartment. Similarly, another organization runs a Family Resource Network that provides

participants with basic needs such as food, showers, laundry services, and temporary shelter. A recovery coach at another organization mentioned that they drop off basic needs at participants' homes. The recovery coach was also assisting a program participant who was incarcerated. They reached out to their probation officer, sent documents, and set up a home plan so that the person could get early release. At another organization that works with justice-involved participants, recovery coaches helped connect participants to vital transportation upon release. A recovery coach at the organization said that this is one of the first things a person needs upon release from prison and that it reduces recidivism.

Other concrete supports provided by recovery coaches help participants on the path to self-sufficiency. A recovery coach described how they refer participants to a job referral organization. One participant stated that recovery coaches took them to job interviews when they were looking for work. A participant at another organization said that they were connected to vocational classes by their recovery coach. Participants at a different organization often receive help getting a cell phone or submitting applications for food stamps and government IDs.

One recovery coach shared their belief in advocating for the program participants to receive various concrete supports, but there are limitations to being able to do so in their role as a recovery coach. For example, recovery coaches at one organization described that while they cannot contact insurance companies, case managers are able to do so. To overcome this barrier, the recovery coach will sit with the program participant while they contact the case manager to ensure they are accountable and receive the necessary support.

Mental Health Support

All 11 organizations described serving participants with co-occurring SUDs and mental health diagnoses and/or undiagnosed mental health challenges. As such, recovery coaches connected participants to mental health supports for individuals struggling with post-traumatic stress disorder (PTSD), depression, or anxiety. This included support groups; connecting participants to mental health classes; connections to mental health-related partner organizations; and making referrals to therapists, counselors, and psychiatrists.

> *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

Two organizations have groups specifically designed to help participants overcome trauma. One of the organizations has a veterans trauma group that uses a cognitive-behavioral approach to treat trauma. A recovery coach at a different organization said they facilitate anger management classes to help participants cope with the anger, shame, and guilt that often come with addiction. A recovery coach at another organization said that they refer participants with severe mental health episodes or challenges to a partner organization that is better equipped to help. AmeriCorps members and recovery coaches at one organization collaboratively help program participants re-

> *Anger management is a valuable skill to have. Some people don't know how to get angry without being high, how to be happy without being high. How to manage emotions period. So learning that is phenomenal for people who they never learned how.*
>
> Program Participant

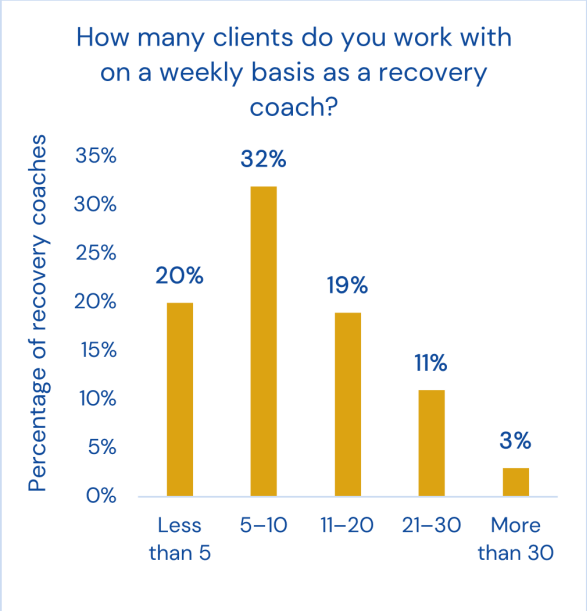
enter their community by helping them overcome the trauma resulting from being victims of commercial sexual exploitation.

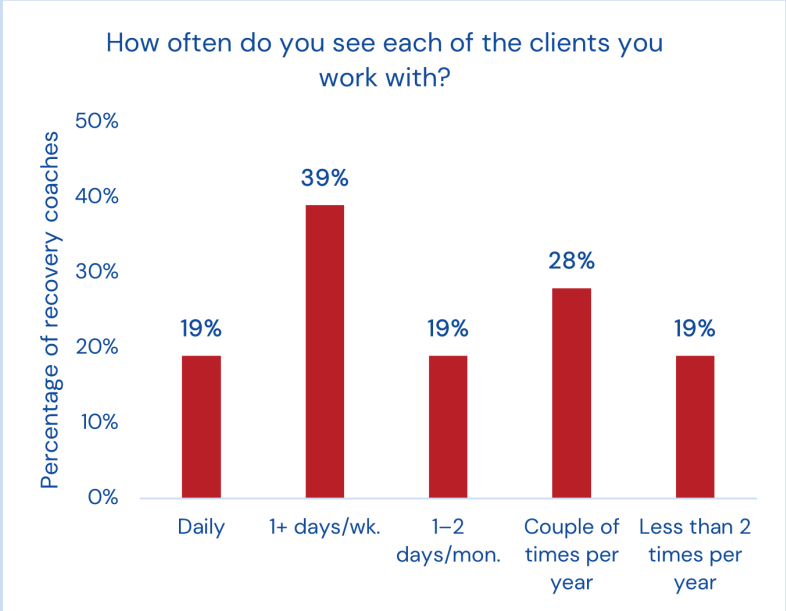
One recovery coach who experienced physical and sexual abuse is matched with participants with similar experiences, expressing that they are able to experience "true empathy." Another recovery coach stated that they work primarily on the provision of mental health support and can share resources they have learned as a result of their own mental health diagnoses (e.g., obsessive-compulsive disorder, anxiety, and major depressive disorder).

Caseload, Duration, and Intensity of Services

Surveyed recovery coaches were asked about the number of program participants 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 (32 percent), with 20 percent working with fewer than 5, and 19 percent working with 11-20 clients. There was a wide range in reported frequency of client sessions; while more than 58 percent of recovery coaches reported that they see each participant at least once a week, 19 percent cited seeing clients fewer than two times per year.

EXHIBIT 4-2.—Number of participants and frequency of sessions (N=72)

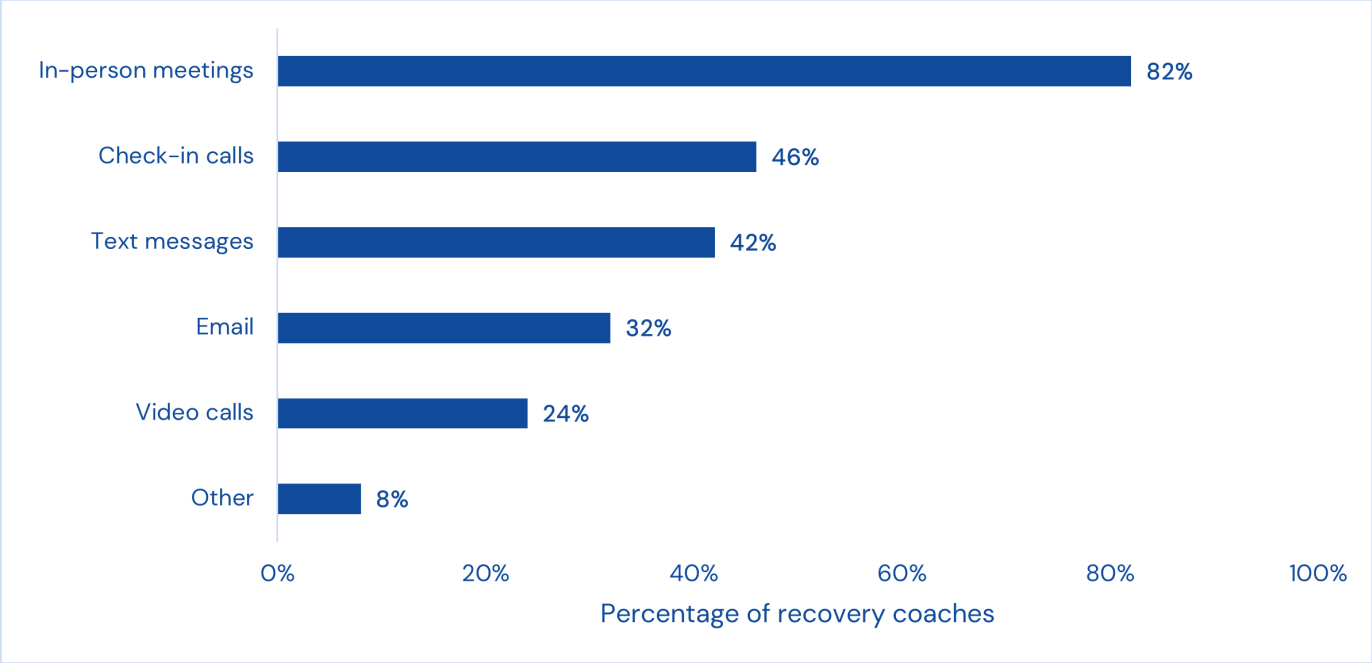




Source: Recovery Coach Survey
Note: Eleven of 72 recovery coaches did not give an answer when asked "How many clients do you work with on a weekly basis?" and all recovery coaches answered the question "How often do you see each of your clients?"

As seen in exhibit 4-3, the majority of recovery coaches had in-person meetings with their participants (82 percent) and 24 percent of recovery coaches met virtually via video calls. Other modes of contact included check-in calls (46 percent), text messages (42 percent), or email (32 percent). During client sessions, recovery coaches provide individual sessions or case management (38 percent), group sessions (31 percent), and service referrals (22 percent).

EXHIBIT 4-3.—Mode of interaction between recovery coaches and program participants (N=72)



Source: Recovery Coach Survey: "What mode of interactions do you have with clients?"

During site visits, recovery coaches were asked to estimate how many program participants they worked with each day and their average 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 the recovery coach's situation, the types of services provided by the organization, and the geographic location. A promising practice identified in interviews with recovery coaches from one organization was the use of an app called REDCap, which coaches use to manage participant data, track their progress, and identify risks and barriers. Recovery coaches at the site found it to be a helpful tool for managing their caseloads.

Many recovery coaches work in outpatient settings with a main location or drop-in center where participants come to meet with their recovery coach and receive other services. Examples of the caseloads, duration, and service intensities for these types of organizations are as follows:

- A recovery coach stated that they work with about 30 participants per week. Most of their work is one-on-one and they do phone and Zoom chats. They meet with participants either daily, weekly, or every other week.
- One recovery coach provides both individual and group sessions. They work with 10–20 people per group/class. The classes can have up to 40 participants. They have completed five one-on-one sessions. They see 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 they see them throughout the week. They also invite them to groups and events. They check emails, returns calls, check with case managers for participant needs, and drop off basic needs at participant homes. They connect 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 has nine active participants in their caseload, five of whom are in recovery for an SUD. They work part time and communicate with their participants via text during the week and meet with each person face-to-face on the weekends for a couple of hours.
- One recovery coach works in an outpatient center and there can be up to 300 people coming through the center every day as they have many walk-ins. They are in a clientele-building role. At any given time, they have a caseload of between 20 and 30 participants. They stated that they work with 3 participants per day in individual, face-to-face 30-minute to hour-long sessions. They also conduct check-in phone calls with 20–30 participants to make sure they are coming in.

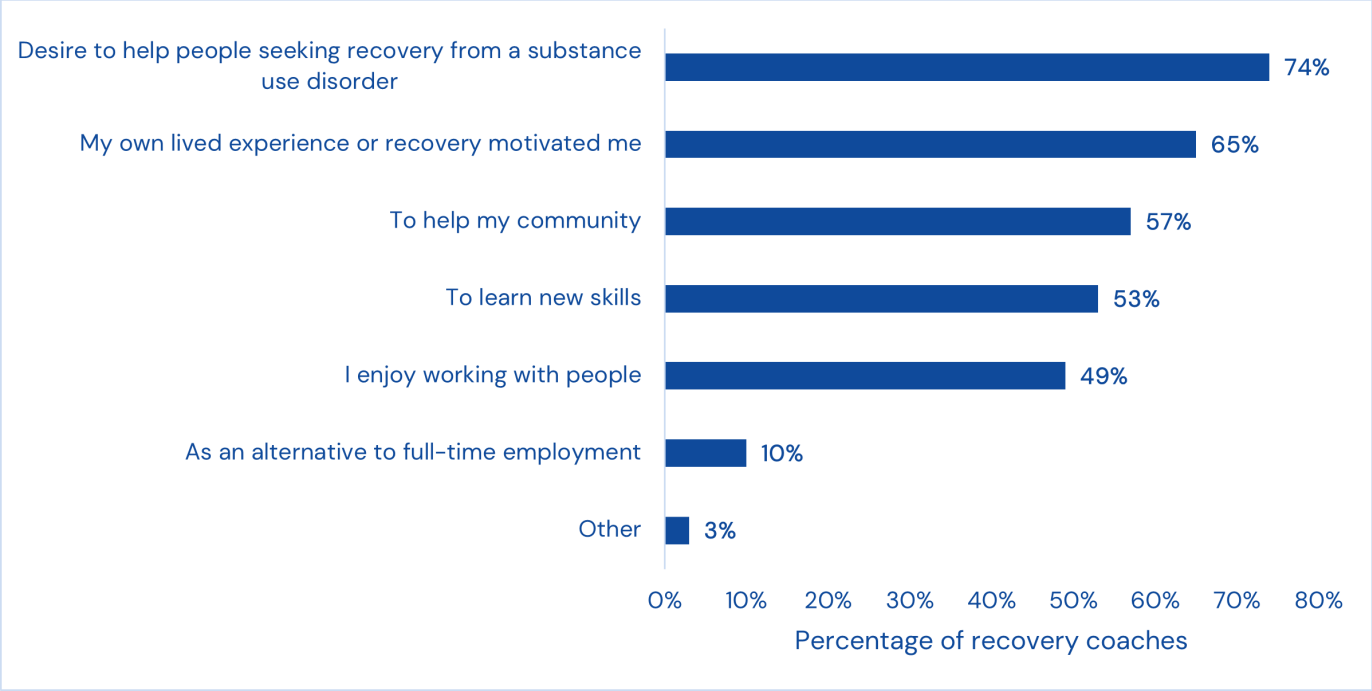
Other recovery coaches work in homeless shelters, intensive residential facilities, or they provide community outreach.

- One recovery coach works at a homeless shelter and sees 6–12 participants each day through individual and group meetings and Narcan trainings. They also spend time in the cafeteria or recreation area recruiting people to the organization who are in active addiction.
- Recovery coaches at two organizations work with participants in intensive inpatient treatment programs, whereby recovery coaches providing round-the-clock services to participants living in the same facility. Another recovery coach at one of these organizations is more focused on community outreach. They visit many locations (such as emergency rooms, parole offices, and churches where addiction is high) and talk to different people every day, giving out information and resources to people in active addiction.
- Another recovery coach does not have a caseload and is focused more on community outreach. They drive a van to different parts of the city and answer questions about the organization and hand out resources and supplies to different people every day.

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 the desire to help others seeking treatment from an SUD (74 percent), their own lived experience of recovery (65 percent), and to help their community (57 percent). Somewhat smaller percentages of recovery coaches reported that they became recovery coaches to learn new skills (53 percent) or because they enjoy working with people (49 percent). Notably, only 10 percent reported becoming a recovery coach as an alternative to full-time paid employment.

EXHIBIT 4-4.—Reasons reported for becoming a recovery coach (N=72)



Source: Recovery Coach Survey: "Why did you choose to become a recovery coach?"

Similar to survey findings, recovery coaches reflected on how their own lived experience with an SUD motivated them to become a recovery coach during site visits. One recovery coach reflected on how they previously received SUD services at the organization where they now serve as a recovery coach since the organization made them feel cared for, loved, and supported and helped them "get back on their feet." They mentioned that while their therapists and case managers were "great," they especially appreciated the support and connection they felt with their recovery coaches, and they were inspired to become a recovery coach themselves so they could model what change and hope look like.

Similarly, another recovery coach stated that they were drawn to recovery coaching because of their own experiences with an SUD. While they personally did not receive support from a recovery coach, they found that individuals they could relate to made the biggest difference. A recovery coach who is in long-term recovery said that working in this field meant that "for the first time in [their] life, [their] background was an asset" instead of a hinderance.

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

Other recovery coaches described that having a family member with an SUD made them want to become a recovery coach. One recovery coach said that it was not only their experience with SUD and homelessness that impacted their decision, but also the struggles that their son and sister had with substance use that motivated them to want to make a difference in others' lives. At one organization, two recovery coaches reported that they chose this profession because of the substance use journey of their immediate family.

Challenges and Solutions

Recovery coaches face difficult challenges inherent to working with individuals with SUDs. For example, **a harsh reality of this work is that program participants may overdose while receiving treatment**. This can be devastating for recovery coaches and presents unique challenges for a coach with firsthand lived experience with an SUD to navigate as they attempt to maintain sobriety while coping with emotions that may trigger a relapse. Two recovery coaches at one organization said that they worried about "getting too close" to participants and expressed concerns about having adequate coping skills to deal with the challenges this job presents. One recovery coach shared that their organization has a ceiling covered with doves with the names of people who have died of an overdose as it sends a powerful message to visitors and program staff alike.

> *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.*
>
> Recovery coach

Many program participants and recovery coaches alike are **coping with the intersectionality of SUDs, co-occurring mental health diagnoses, and may also be dealing with histories of trauma**. In some instances, this allows the recovery coach to draw upon their traumatic history to help others. However, this experience can also be emotionally taxing for the recovery coach. In these instances, recovery coaches discussed having to remove themselves from a session in order to ensure their own emotional self-care.

Recovery coaches from one organization 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." They 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. Another recovery coach shared that there is a lot of pressure to get participants to resources as soon as possible before they relapse, go back to jail, or overdose.

For **recovery coaches with direct lived experience with an SUD, maintaining their sobriety is a top priority, and often a challenge**. For one recovery coach, the biggest challenge was continuing to work on and maintain their own recovery. At another organization, one recovery coach who is in recovery from an SUD agreed that there are triggers for recovery coaches, including the loss of valued relationships when there is staff turnover. Two recovery coaches at different organizations shared that setting both emotional and work boundaries was important to maintaining their recovery.

> *The challenge is a lot of these women when they come, especially the ones that come out of the jail system … they have a guard up from coming out. Establishing the rapport might be the hardest part.*
>
> Recovery coach

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. Two recovery coaches at one organization discussed the difficulty of setting up appointments and meetings for participants who ultimately do not or cannot follow through. According to a coach, "There's like a balance in trying to do everything for them." At another organization a recovery coach reported that their biggest challenge was the waning "willingness of participants." One recovery coach mentioned that at their location, people come in for medication assisted dosing and then leave, which can be frustrating. The population they

serve is in early recovery and there is no requirement for group meetings, so the difficulty is keeping people motivated and on-task. They said that it is on the individual to have the motivation to recover.

Other challenges were related to the site location. Two recovery coaches at one organization who work at partner locations expressed that they lacked adequate authority and access to information at these sites. Another recovery coach at the organization experienced hostility from other staff at these partner sites and said that support from their organization and AmeriCorps was helpful when this happened. One recovery coach at a different organization discussed the difficulty of trying to implement harm-reduction strategies in their geographic 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. The recovery coach mentioned that there were outbreaks of hepatitis and HIV and they were trying to keep people healthy and save lives. However, they were unable to change those misconceptions.

Recovery coaches at three organizations stated that a barrier was working with different cultures and ages of their participants. To overcome this challenge, one recovery coach does research on different cultures and religions to better relate to their participants. They believed that doing so allows them to be more relatable and make a positive difference for more participants. One recovery coach shared that the cultural barrier was intergenerational, and that learning to communicate to younger generations was the challenge. Another recovery coach described themselves as a "pansexual gender nonconforming White [person]" working with "older Black gentlemen." They stated that they can relate to them on many recovery-related issues but cannot relate to how they grew up. They do whatever they can to understand but some participants do not think they can help because of this cultural difference.

Organizations also shared challenges that influence their community's ability to support their program's target population, including limited access to and awareness of resources and services. A lack of available community resources and services to support people in recovery was attributed to the rural location for two organizations. Program participants from two organizations noted that resources and services needed to be more inclusive of the diverse needs of program participants (for example, services for hearing impaired participants, materials translated into other languages, and translation services for emerging populations). One organization that offers a free program for participants and is solely supported by grants and donations expressed that they are limited by the size of their facility. Consequently, they often need to give food donations to other shelters because they do not have space for storage. Three organizations expressed curiosity about any additional resources or supports at the program level or at the national level that may be available from agencies such as AmeriCorps. Program participants from one organization—which provides housing and other supports for pregnant women and mothers experiencing homelessness, including those in recovery from an SUD—noted they did not know about all of the services available through the program, including the existence of recovery coaches. VISTAs at one organization were not aware of all the practices or programs within their assigned organization's program.

Support for Recovery Coaches

As discussed in the Recovery Coaching Programs chapter, 85 percent of organizations have monitoring and oversight plans for recovery coaches. This includes monitoring their well-being, which can be bolstered by the opportunity for coaches to support one another. In the project director survey, 90 percent of organizations reported that they provide opportunities for recovery coaches to connect with each other.

To deal with the many inherent challenges associated with serving as a recovery coach as described in the previous section, all organizations reported that they provide targeted support to help recovery coaches to do their job and maintain their sobriety. Recovery coaches from one organization said that their recovery coach group chat was a form of support for them. At a different site, recovery coaches from this organization found weekly group meetings with all recovery coaches to be helpful. Another organization reported that their recovery coaches meet as a group twice a week to collectively process issues and challenges they regularly face. A recovery coach from another organization mentioned that there is another recovery coach at the center and they were "an absolute blessing to have" due to their lived experience of 30 years of sustained recovery. The recovery coaches also have support from leadership at their organization. One recovery coach discussed the support from their supervisor, who helped in the first few months when they were overwhelmed with the work. Another recovery coach stated that the recovery coaches and leadership are in constant contact, which they find helpful.

> *Here at [organization], from the executive director down to the [recovery coaches], it's just a therapeutic community and a support system.*
>
> Recovery coach

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

Program Outcomes

As described in the Methods and Data Sources chapter, outcome indicators based on survey and interview/focus group protocols assessed whether 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 organizations are presented. The perceived influence on recovery coaches' ability to work with program participants is also discussed. The original study design sought to investigate whether recovery coaching treatment programs would be associated with better outcomes than those with an absence of recovery coaching. However, without a robust comparison group for analyses, this study instead assessed whether program participants' time spent with their coaches (in frequency and in duration) would be linearly associated with average recovery capital scores, uptake of services, and reduction in use of substances.

Organization Outcomes

The main outcomes for 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 from "strongly agree" to "strongly disagree" for a statement about organizational capacity ("My program has the organizational capacity needed to provide services"). Seventy-five percent of project directors agreed or strongly agreed that their program has the organizational capacity to provide services, while 25 percent disagreed or strongly disagreed. Findings from the interviews with project directors suggested directors feel confident in their organization's capacity. A project director from one organization shared that the VISTA program was instrumental in building organizational capacity. They attributed part of their growth from a budget of $200,000 to over $1 million to the VISTA program. Two organizations reported that their clients are receiving more services because of their access to AmeriCorps members. One director noted the positive influence of AmeriCorps members who bring in new experiences and ideas that benefit their program. Another director noted that AmeriCorps members expand their organization's capacity particularly in the rural region they serve by helping to break down communication barriers. Similarly, another organization credits AmeriCorps member support for expanding their visibility within their community.

In addition to assisting with reporting, project management, and capacity building, AmeriCorps members also coordinated with higher education institutions to recruit up to 70 interns seeking to complete their Practicum for a master's degree in counseling. Another organization provides recovery coaching in Minnesota and Illinois and is expanding to California and Virginia through support from AmeriCorps. A project director at a different organization also shared that AmeriCorps financial support and technical assistance has allowed their organization to train more staff to prepare them to "tackle the multiple public health issues" their organization deals with.

Ability to Leverage Grant Financial Support

Seventy percent of project directors agreed or strongly agreed that their program can leverage grant financial support, and 30 percent disagreed or strongly disagreed. In interviews, all organizations reported the use of outside grant support to fund their services. All organizations received private and/or public funding in addition

to AmeriCorps funds, however, none of the organizations received a federal opioid development grant.[8] One organization 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 had 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, one organization reported receiving funds through the Saint Louis 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).

Two organizations were affiliated with state and/or local governmental agencies and received funding from those sources in addition to other grants. Other state funding sources included the Georgia Department of Behavioral Health and Developmental Disabilities and the Tennessee Department of Mental Health and Substance Abuse. Sources of funding also included SAMHSA grants and a U.S. Department of Health and Human Services grant.

One organization 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. Two organizations were able to use VISTAs and recovery coaches to help with grant writing. One organization recently applied for a harm reduction grant with Smart Recovery in Ohio. Smart Recovery and the organization plan to expand harm reduction and substance use alternative programming to rural communities.

Collaboration with Partners and Community Resources

Seventy-five percent of 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 the Recovery Coaching Programs chapter, the 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 organization has over 100 linkage agreements with organizations around Chicago. These organizations provide health and behavioral services, food, clothing, housing assistance, and furniture. This organization 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 their organization's partners refer participants to them for services.

[8] NYC Department of Health and Mental Hygiene and Maggie's Place reported that they have a city-level opioid grant and a Ford Foundation opioid grant, respectively.

Another organization now houses a statewide coalition against trafficking and exploitation, and it has made them a connection point for anyone doing any antitrafficking 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. The organization 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 (e.g., 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 train them to scale up the church's services.

A different organization has a large network of partners that includes churches, government entities, and nonprofit organizations. Local churches host recovery program activities. A pastor's group connected to these churches provides outreach and recruitment of participants and staff. Another partner works closely with the state district courts to help participants work through legal challenges and steer some people away from prison and into recovery programs at the organization. The partnership with the courts is beneficial for both sides because the organization can house and feed people in recovery housing and ensure they appear for court by providing transportation. This partner also works to help participants escape homelessness through a "tiny homes" program.

> *We have an event where all the partners come out. You'll see a tent outside for AIDS test or TB test or whatever. … Then you'll have the guy from the SNAP program where you could sign up for food stamps. Then you have other nonprofit organizations handing out bags with toiletries in it and clothes. We all come together as one.*
>
> Recovery coach

> *I think [communication with other partners] helps us serve clients much better. And we're sharing resources. One of the purposes of meeting is to say, 'What are the issues that you're seeing?' And as a group we put our heads together and say, 'How are we going to fix this?'*
>
> Partner

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.

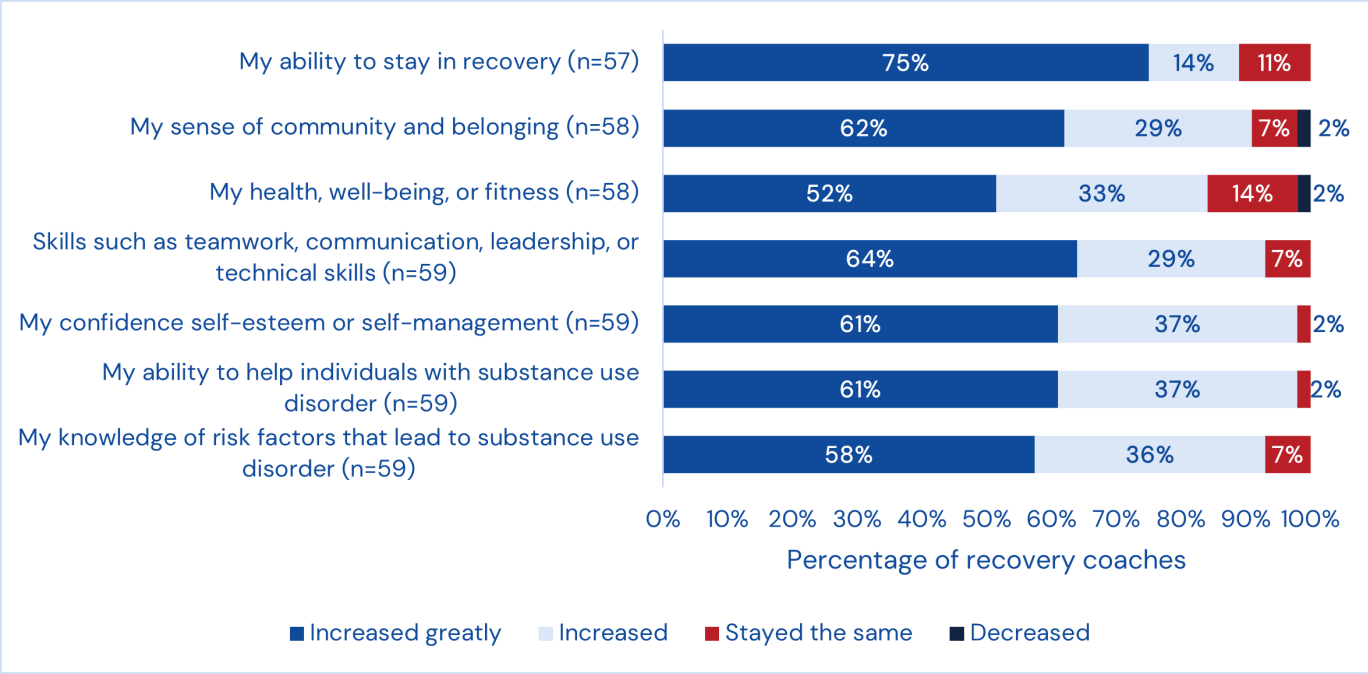
Perceived Changes in Knowledge, Attitudes, and Behaviors

Recovery coaches rated their changes in knowledge, attitudes, and behaviors since becoming a coach (exhibit 5-1) on a 5-point scale ("increased greatly," "increased," "stayed the same," "decreased," or "decreased greatly"). For each of the 7 items, 85–98 percent of coaches reported the knowledge, attitude, or skill "increased" or "increased greatly," indicating a strong agreement that they have experienced a multitude of benefits since becoming a recovery coach:

- 98 percent reported increased confidence, self-esteem, or self-management;
- 89 percent reported increases in their own ability to stay in recovery;
- 98 percent reported increases in their ability to help individuals with SUDs;

- 93 percent reported increased skills such as teamwork, communication, leadership, or technical skills;
- 91 percent reported an increased sense of community and belonging;
- 94 percent reported increased knowledge of risk factors that lead to SUDs; and
- 85 percent reported increased health, well-being, or fitness.

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



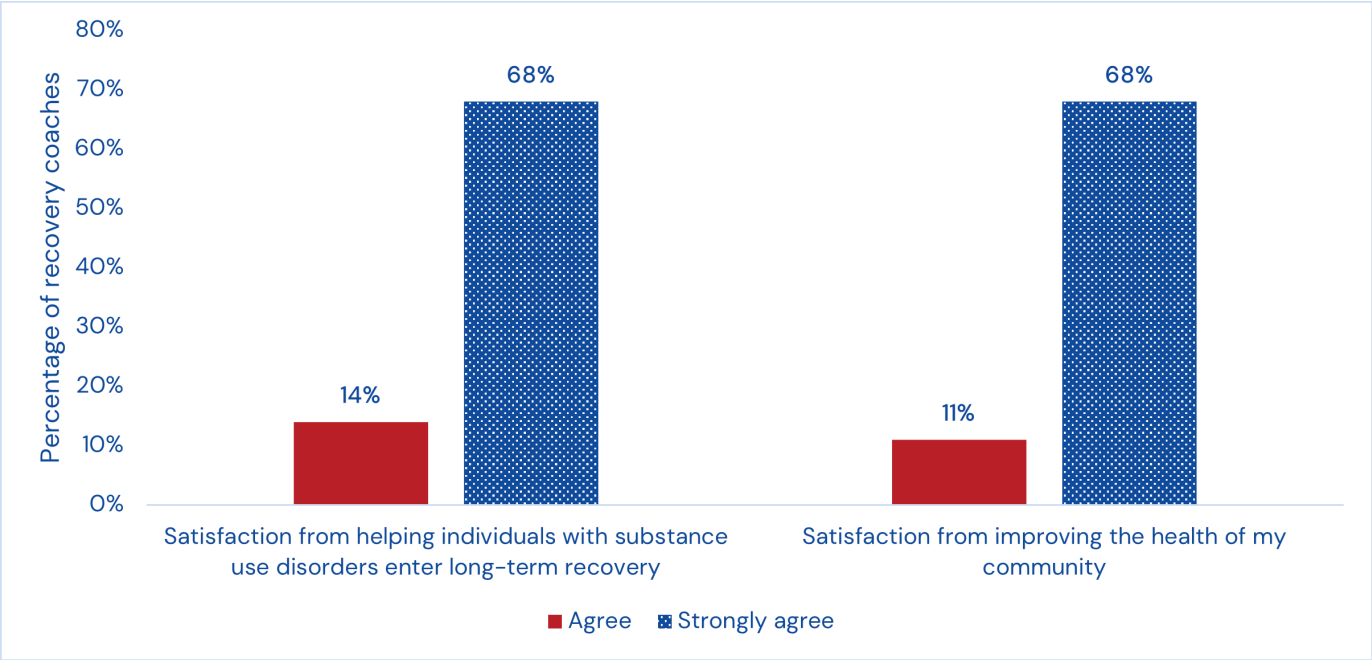
Source: Recovery Coach Survey: "Please rate the following statements based on whether each factor has increased or decreased for you since becoming a recovery coach."
Note: Totals may not add up to 100 due to rounding.

During interviews and focus groups, recovery coaches and directors from seven organizations expressed that recovery coaching helps coaches in recovery from an SUD maintain their recovery. One recovery coach discussed that recovery coaching as a career played a critical role, not just in motivating participants to get clean, but in helping recovery coaches staying clean. Now, being a coach supports their recovery because they serve as a role model to others. Another recovery coach noted that being a recovery coach helps them stay sober and gives them a sense of purpose. One recovery coach responded that being a coach has helped them as they never "clicked" with AA or NA despite being told that if they did not do AA, they would not recover. One director noted that while none of their recovery coaches in recovery had relapsed during their time working at the organization, they recalled that some did relapse after leaving their organization.

> *The model is peer-to-peer, you know, we're all in it, whether you got 1 year, 2 years, or 18, we're learning from each other. And that's like one of the greatest benefits … it helps me be inspired to stay in recovery.*
>
> Recovery coach

Exhibit 5-2 presents the benefits of being a recovery coach. Overall, recovery coaches received satisfaction from helping people with SUDs enter long-term recovery (82 percent agreed or strongly agreed) and improving the health of their community (79 percent agreed or strongly agreed).

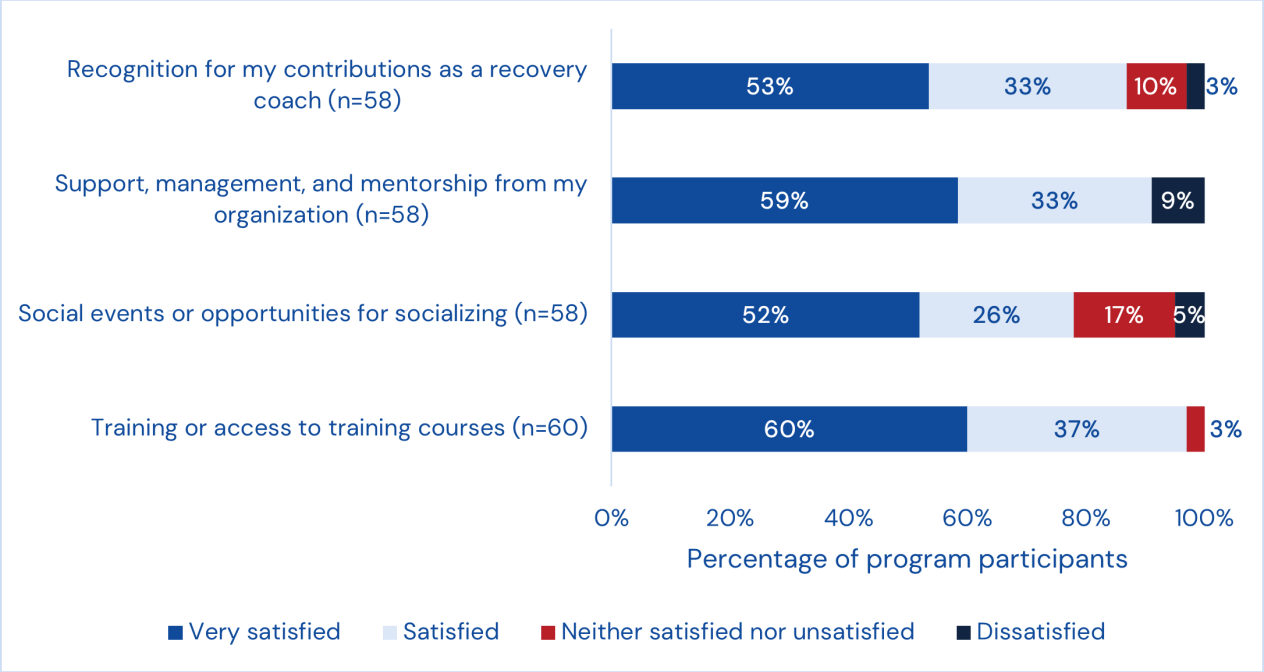
EXHIBIT 5-2.—Self-reported benefits of being a recovery coach (N=72)



Source: Recovery Coach Survey: "How much do you agree or disagree that you get these benefits out of being a recovery coach?"
Note: Thirteen of 72 recovery coaches did not answer the question about their satisfaction from helping individuals with SUDs, and 15 of 72 did not answer the question about their satisfaction from improving the health of their community.

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 (92 percent) and recognition for their contributions (86 percent). However, only 78 percent of recovery coaches were satisfied or very satisfied with socialization opportunities or events. During interviews, recovery coaches expressed that they were generally satisfied with the support they received from their respective organizations. Recovery coaches at two organizations likened the organizational culture to a family environment.

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



Source: Recovery Coach Survey: "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 recovery capital, attendance to physical and behavioral health services, and incidence of substance use.

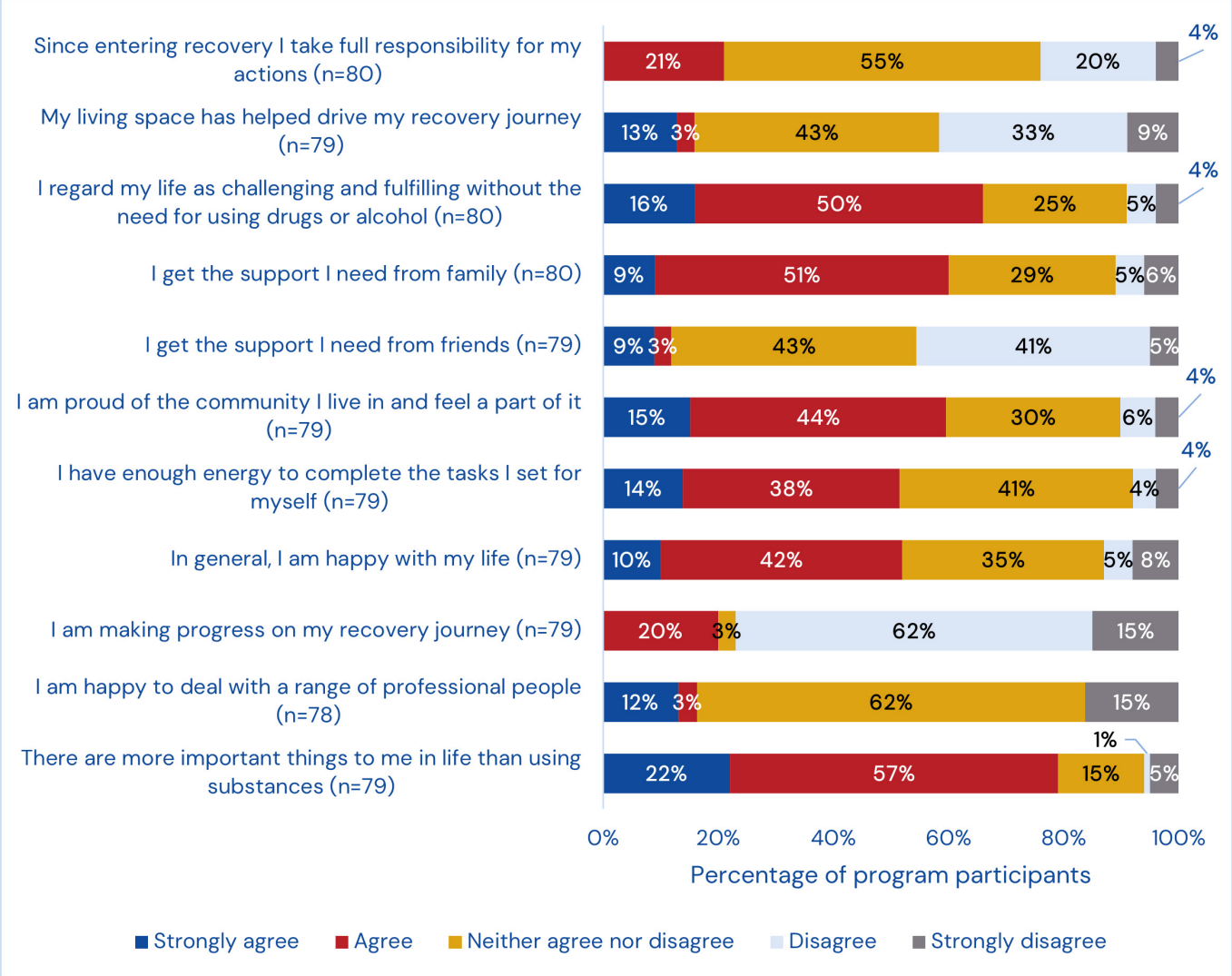
Recovery Capital

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" (1) to "strongly agree" (5). The scores were averaged rather than summed for each respondent as a strategy to include as much data in analysis as possible when missing data were present. This study's sample had a mean score of 3.2 (SD = 0.7), and a range of 1.18–4.82. The sample's responses for each recovery capital survey item are summarized in exhibit 5-4. Promisingly, most participants agreed or strongly agreed to statements such as "I regard my life as challenging and fulfilling without the need for using drugs or alcohol" and "There are more important things to me in life than using substances." However, there was a wide range of responses across the items; for instance, 77 percent of respondents disagreed or strongly disagreed with the statement that they were making progress on their recovery journey. This range in responses suggests the multiple, complex dimensions of perceived self-efficacy may exist for program participants.

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



Source: Program Participant Survey

The descriptive statistics for recovery capital were complemented quantitatively by regression models to test hypotheses that more time spent with a recovery coach would be significantly associated with higher recovery capital. Two models were executed using survey data from program participants—the first regressed the categorical response to the survey item "How many hours per week do you work with a recovery coach?" (Less than 1 hour, 1–4 hours, 5–8 hours, 9–16 hours, or 17 hours or more) on the participant's mean recovery capital score. The second model regressed the categorical response to the survey item "How often do you communicate or check in with your recovery coach?" (Multiple times a day, once per day, 1–4 times/week, 1–2 times/month, or a couple of times per year) on the participant's mean recovery capital score. Both models controlled for gender to reduce confounding with the outcome.

Results suggest a statistically significant association in which participants that self-report spending 9–16 hours/week with their recovery coach had on average a 1-point higher mean recovery capital score (range 1–5) than those who spent less than 1 hour/week with their coach (*b* = 1.01, std. error = 0.47, *p-value* = 0.03). Given the range of recovery capital scores, this is considered a large effect. 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. More studies are also needed to confirm that 9–16 hours of coaching is a meaningful and distinct quantity, or whether linear models that operationalize time in a continuous sense might reveal incremental increases in recovery capital with increases in hours spent with a coach.

Findings from interviews and focus groups mainly align with and complement the survey findings related to recovery capital, particularly with the provision of **basic household items**. One participant stated that if you do not get something, it is because you did not ask for it. For example, they get items such as trash bags and dish soap and do not feel embarrassed asking for help. Participants at five organizations discussed **gaining employment**, some of whom became recovery coaches at the organization. An AmeriCorps member shared that they had watched participants go on to get “straight A’s in college” and get nursing degrees.

Participants at eight organizations spoke about the **improvement in their quality of life**. A participant shared that the program helped them “get off the streets.” Another participant shared that when they came to the organization, they were homeless, about to lose their family, and addicted to heroin. They now practice better hygiene, have a home, a bank account, and are starting to rebuild their self-confidence and relationships with family members. All of these benefits they attribute to being inspired by the recovery coaches and other program participants. As they 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.*

> *I didn’t have a life before [organization]. … The life I had; I didn’t want it. This place opened my eyes to way more than I thought it could be. They taught me how to be a man here, how to be responsible and accountable … . How to be happy in my own skin.*

Another participant shared that they are back in school for criminal justice, concentrating in human services. They feel that they are 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 also cited other recovery coaching program benefits such as **improved self-esteem**, **increased knowledge**, and an **increased ability to navigate challenges**. A participant shared that they can now speak to people about anything they need to work through. Another participant said that they can communicate with others in a better way now. One participant shared that they are learning how to manage PTSD and their history of trauma in a healthy and safe manner instead of using substances. A participant said that after working with a recovery coach, they value their life more and love themselves more. Another participant shared that recovery coaching taught them structure and boundaries as well as the need for self-love in order to love others. They were scared when they first came to the organization but now feel like they are moving in the right direction. Another participant shared that they now know they deserve better than what happened to them in the past.

> *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 at one organization mentioned that current participants are inspired when they see other mothers leave the program. A participant was shot in 2019 and the recovery coach told them, "When you get through healing, you come back and we're going to be here for you," which the participant believes helped them to stay with their recovery journey. Another participant works in the organization's garden, and it gives them hope because they get to see the resilience of the plants and how they can implement that in their own life. A participant described that the program had made a difference in many parts of their life:

> *I got my family back; I am not isolated. I don't want to kill myself any more. I'm not depressed. I don't sit in grief. I actually like … smile. I feel like I am living a life now instead of just existing, you know, that's awesome.*

A participant remarked that they did not have a life before the organization helped them recover. One participant announced "210 days sober" and received a round of applause from the other focus group program participants. Another participant stated that the organization calls them on their "clean date" every year and celebrates with them.

Program participants also reported that they found a **community** and had **strong relationships** after joining their respective recovery coaching program. Parents at three organizations reported that they learned to be better and more present parents after joining their program. A participant from another organization said that their recovery coach helped them appreciate others and gain healthy relationships within their family. Participants from five organizations referred to the people in the organization as their family. A participant said that although sometimes they argue, when participants see each other out in the city they always have each other's back and help each other out. One participant said, "Everyone is like a family," adding:

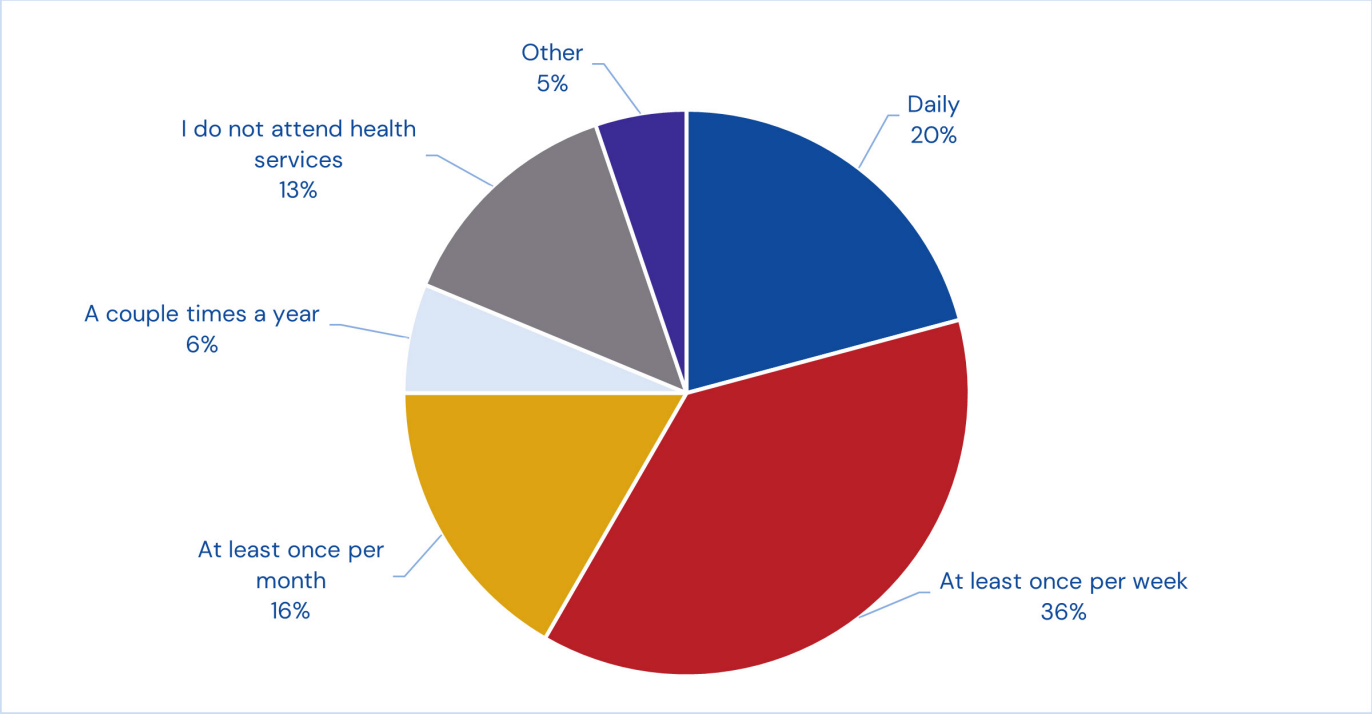
> *I went back into a dark place in my life and I thank God for [the organization] because it was the people I had built relationships with here that reached out to me and called me and said I was worth saving.*

Physical and Behavioral Health Service Attendance

Substance use disorders often come with co-occurring physical and mental health issues. Attending physical and behavioral health services ensures that individuals receive holistic care, addressing both their substance

use and any related health concerns. The survey asked program participants, " Since entering recovery, how often have you used physical and/or behavioral health services on average?" and accepted categorical responses (every day, at least once a week, at least once a month, at least once a year, I do not attend health services, and other). As illustrated in exhibit 5-5, more than half (56 percent) of participants attend services at least once per week or daily, but 13 percent of participants report that they do not attend health services.

EXHIBIT 5-5.—Program participants' use of physical and/or behavioral health services (N=83)



Sources: Program Participant Survey: "Since entering recovery, how often have you used physical and/or behavioral health services on average?" Three participants did not answer this survey question.

As with the recovery capital outcome, two regression models were run to investigate whether time spent with recovery coaches is predictive of health service use. The first model used the frequency of check-ins as the predictor, and the second model used number of weekly hours as the predictor (see Recovery Capital section for detailed survey wording). Neither regression models suggested a significant relationship between time spent with a recovery coach and self-reported use of services.

Substance Use

Another behavioral indicator was substance use. Program participants were asked about substance use in the past 30 days and gave a categorical response (every day, at least once a week, at least once a month, or I have not used drugs in the last 30 days). The majority of participants reported never using substances in the last 30 days (84 percent). Two percent each reported using substances at least once a week or at least once a month. It was unclear whether the participants that reported some substance use partook in harm-reduction services as part of their treatment plan.

Regression models did not suggest any significant association between time spent with a recovery coach and self-reported substance use in the past 30 days. However, given the low variability in reported substance use, the data likely forbade detection of effects, if any.

Satisfaction with the Program

Program participants were asked to rate their satisfaction with their program through three survey items: "How likely are you to recommend this program to another person who is dealing with addiction?"; "How do you rate the quality of services you have received with your organization?"; and "How do you rate the quality of services your recovery coach provides?" Overall, program participants expressed favorable ratings:

- Over three-quarters (76 percent) of survey respondents were “very likely” to recommend the program and 17 percent were “likely” to recommend the program. Five percent were ambivalent and were neither likely nor unlikely to recommend the program, while only one individual reported "unlikely.”
- Three-quarters (75 percent) of survey respondents rated the quality of services received with their organization as “excellent” and 20 percent rated the quality as “good.” Five percent reported "fair" quality and no participants rated the program quality as "poor.”
- Over half (57 percent) of survey respondents rated the quality of services provided by their recovery coach as "excellent," 17 percent reported "good," and only one individual each reported "fair" and "poor."

Evaluation Capacity Building

Evaluation capacity building (ECB) was provided through 12 hour-long technical assistance sessions delivered on a monthly basis. Cohort 1 participated in ECB between December 2021 and November 2022, and Cohort 2 participated between March 2023 and March 2024. The overall purpose of the ECB was to enhance participants' capacity as evaluation practitioners. The sessions (detailed below) also aligned with the goals of the current evaluation by helping grantees to understand their participation in the evaluation. For example, ECB sessions on rigorous survey development contributed to participants' ability to provide constructive feedback on draft instruments.

ECB sessions were divided into three modules: (1) Planning Evaluation; (2) Implementing Evaluation; and (3) Reporting and Using Evaluation. The curriculum was based on AmeriCorps evaluation capacity building core curriculum with extensive tailoring to the recovery coaching context, especially through examples and discussion prompts that invited participants to apply evaluation concepts to their experiences. 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.

The ECB component of the project was designed to complement the bundled evaluation and support evidence building for the recovery coaching model. First, in the short term, ECB 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 providing a venue for grantees to voice feedback on their experience participating in the bundled evaluation, ECB sessions strengthened the bundled evaluation and the evidence it produced.

In the longer term, ECB supported participants' knowledge and confidence in evaluation topics. In turn, participating organizations would be better equipped to generate future evidence on recovery coaching in the long term by planning and implementing evaluations in their own specific contexts going forward.

An external evaluator, BCT Partners, conducted a mixed-methods evaluation of the ECB sessions 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. 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 by a member of the BCT evaluation team.
- A pre- and post-survey that assessed participants' knowledge of and attitudes toward evaluation topics at the beginning and conclusion of the entire curriculum.

In this section, we describe the implementation and outcomes from the ECB. We present the two cohorts separately when reporting the session-by-session findings, including satisfaction with the content and

knowledge about topics covered in the session, because the delivery occurred at separate times and there were minor modifications to the content and delivery between cohorts based on feedback from Cohort 1. However, when presenting the summative effects of ECB on participant knowledge of and attitudes toward evaluation topics, both cohorts were treated as a single intervention group because the intended outcomes, theory of change, and data collection instruments were the same for both cohorts, and combining the data yielded a higher number of responses for our analysis.

Implementation of ECB

Across both cohorts, there were 24 representatives from a total of 11 organizations who attended at least 1 ECB session. These representatives included project directors, program officers, clinical directors, and other organizational staff.

In Cohort 1, there were 16 participants from 6 organizations who attended at least 1 session. The median number of attendees per session was 6 and the range of participants per session was 2 to 11.

In Cohort 2 there were 8 individuals from 5 organizations who attended at least 1 session. The median number of attendees per session was 5.5 and the range of participants per session was 3 to 7.

In both cohorts, the number of participants per session decreased in later sessions (exhibit 6-1). In part, this can be explained by attrition from the bundled evaluation in general, and some participants' schedules no longer accommodating the scheduled session times. Some email-based inquiries requesting access to session recordings suggested participants who missed sessions may have viewed the recordings instead. One strategy to address attrition in future ECB initiatives would be to condense the sessions into a smaller number of longer sessions, for example, by making each module a single, half-day event. This approach would reduce the number of discrete times a person needs to reserve on the calendar.

EXHIBIT 6-1.—Attendance per module

Session	Cohort 1	Cohort 2
Title	Survey Respondents/Attendees	Survey Respondents/Attendees
Introduction and Evaluation Basics	4/7	5/6
Getting to Know One Another	8/11	N/A
Theories of Change	8/9	5/6
Logic Model	5/6	5/6
Evaluation Planning	5/6	6/7
Preparing to Collect Data	2/6	5/6
Feedback on Bundled Evaluation	3/4	4/6
Data Collection Techniques	5/7	4/5
Data Analysis	2/6	3/4
Deep Dive: SME Presentation on Recovery Coaching Research	N/A	4/3*
Evaluation Reporting	3/3	2/3
Using Evaluation for Program Improvement and Continuous Learning	3/3	4/5

Session	Cohort 1	Cohort 2
Title	Survey Respondents/Attendees	Survey Respondents/Attendees
Interpreting Data from the Bundled Evaluation	2/2	3/3

*The number of survey respondents could exceed the number of attendees at the live session because participants who watched the presentation recording were invited to complete the post-session survey.

Satisfaction with ECB

After each session, participants were asked to rate their satisfaction with the session on 1–5 scale, where 1 meant "very dissatisfied" and 5 meant "very satisfied." In general, participants in both cohorts were very satisfied with the learning experience provided through the ECB sessions (exhibit 6-2). All sessions in both cohorts had a mean satisfaction rating higher than 4.

Across both cohorts, there were three sessions for which every respondent provided the highest satisfaction rating: Preparing to Collect Data; Evaluation Reporting; and Using Evaluation for Program Improvement and Continuous Learning.

In Cohort 1, all respondents also gave the highest satisfaction rating to the session Feedback on the Bundled Evaluation, during which the bundled evaluation principal investigator provided an update on evaluation activities and solicited grantees' input on data collection strategies. This was also highly rated in Cohort 2, although one participant in the second cohort rated their satisfaction as 4 out of 5.

EXHIBIT 6-2.—Mean Satisfaction with ECB sessions (1-5)

Session	Cohort 1	Cohort 2
Introduction and Evaluation Basics	4.21	4.67
Getting to Know One Another	4.48	N/A*
Theories of Change	4.13	4.73
Logic Model	4.42	4.25
Evaluation Planning	4.29	4.47
Preparing to Collect Data	5	5
Feedback on the Bundled Evaluation	5	4.63
Data Collection Techniques	4.6	4.63
Data Analysis	4.75	4.5
Deep Dive: SME Presentation on Recovery Coaching Research	N/A*	4.47
Evaluation Reporting	5	5
Using Evaluation for Program Improvement and Continuous Learning	5	5
Interpreting Data from the Bundled Evaluation	4.5	4.89

*This session was not offered

Each post-session survey also provided space for participants to leave open-ended comments about their experience, including aspects they liked and what they thought could be improved. In both cohorts, a major theme was that participants liked the opportunities for discussion and interaction. For example, one participant wrote that they liked "the slides as well as discussion," adding, "[The instructor] and team made asking questions and interacting very accessible, and I appreciate the visual and hands-on learning." Another participant commented, "I enjoy the visuals and the clear definitions [of terms]." The BCT observer also noted

that the instructor was clear in explaining material and was helpful for participants' understanding of the material and fostering engagement in the session. BCT also observed that participants were engaged during breakout sessions.

Participants' recommendations for improvement were primarily requests for more opportunities for peer learning and more examples tailored to recovery coaching. In response, more time for breakout discussions was added, with prompts for participants to share evaluation challenges they have faced and solutions they have implemented. In response to requests for more tailored content, a session in Cohort 2 was added during which subject matter experts in public health led a session devoted to the unique challenges and opportunities for better research on recovery coaching and other interventions aimed at substance use disorder.

Insights into Recovery Coaching Evaluation Challenges and Opportunities from Session Discussions

Every session included opportunities for participants to discuss their evaluation challenges and opportunities. Across both cohorts, 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 through 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 said 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.

Pre- and Post-Survey Outcomes

The pre- and post-capacity building assessment survey assessed participants on five outcomes:

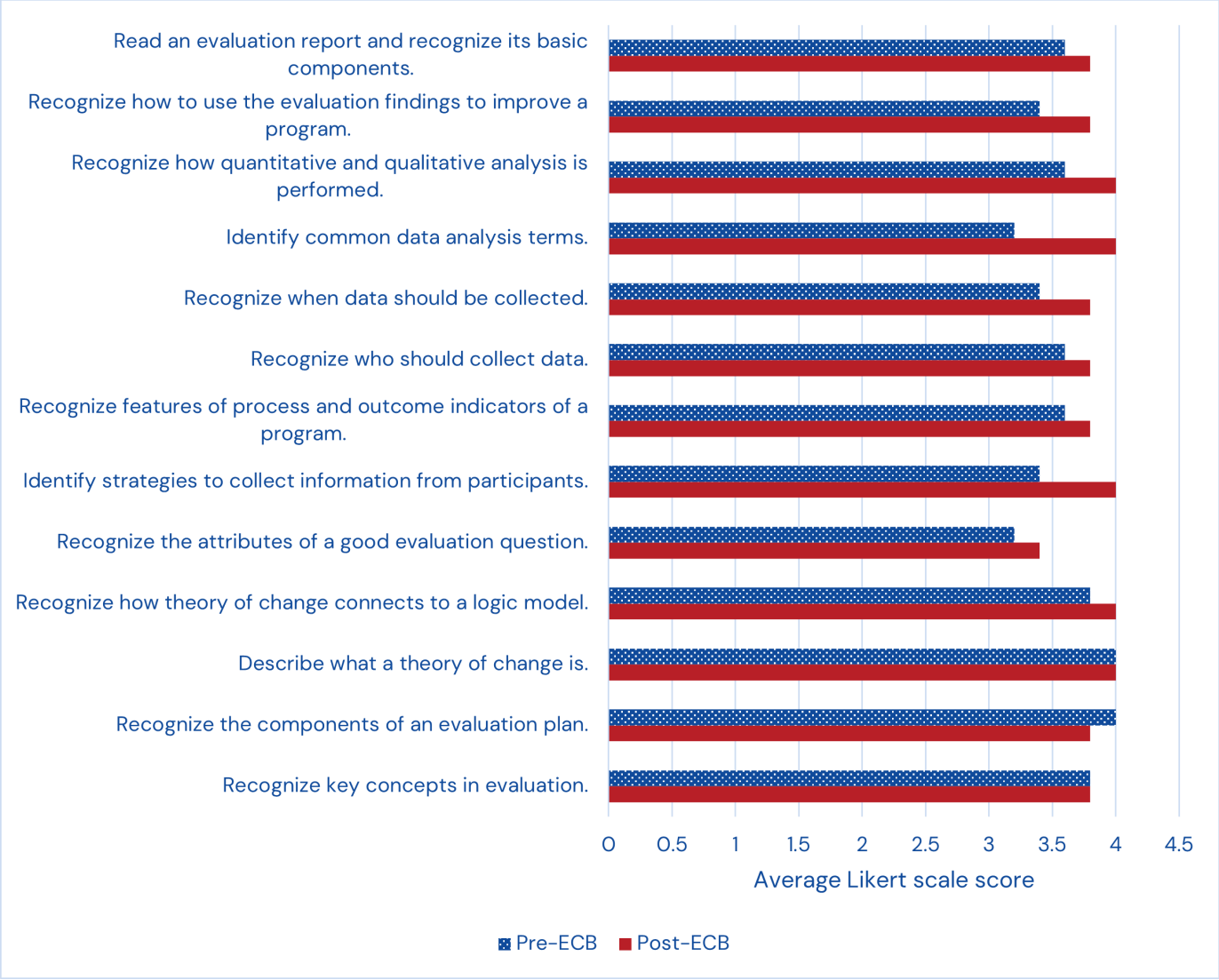
- Perception of their knowledge of evaluation,
- Frequency of evaluation behaviors,
- Attitudes toward evaluation,
- Motivation to conduct evaluation, and
- Barriers that prevent engaging in evaluation.

The following analysis is based on responses from the five participants who took both the pre-assessment and post-assessment. The inclusion of only matched pairs allows for a direct comparison of their scores before and after the ECB efforts, although the small sample size limits confidence in the findings or their

generalizability. These findings serve to report a trend and cannot be used to infer statistically significant differences.

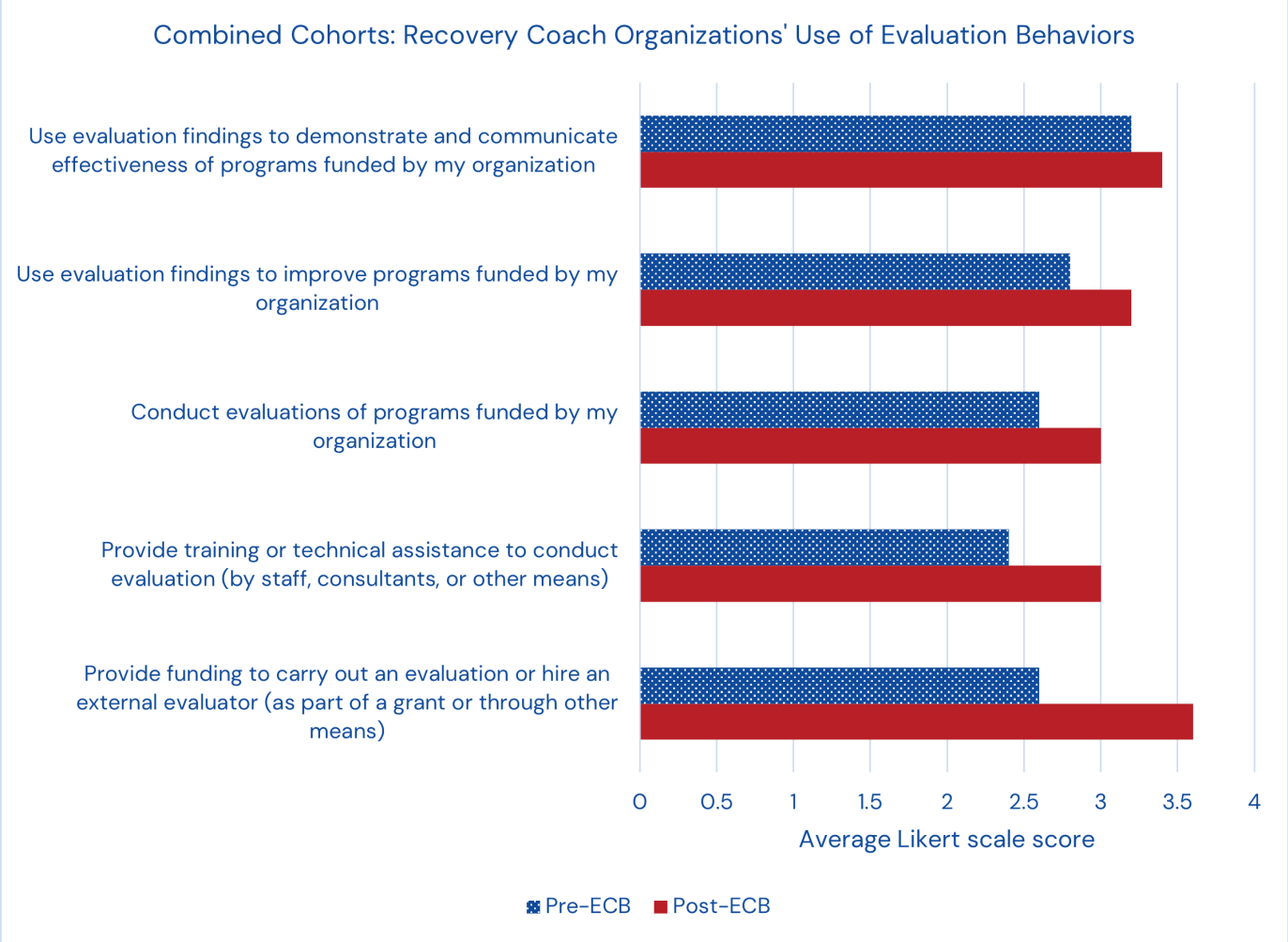
Perceived knowledge of evaluation topics. Participants were asked the extent to which they felt they had knowledge of various capacity building objectives, responding 1 ("not at all") to 5 ("always") when asked if they know information about specific learning objectives identified in the capacity building modules. Participants' perceived knowledge of evaluation topics increased between the pre- and post-survey for 10 out of 13 topics, did not change on 2 topics, and decreased for 1 topic (exhibit 6-3). The topics with the greatest increases in perceived knowledge were: identifying common data analysis terms, identifying strategies to collection information from participants, recognizing how to use evaluation findings to improve a program, recognizing how quantitative and qualitative analysis is performed, and recognizing when data should be collected. The only topic on which participants' perceived knowledge decreased was recognizing components of an evaluation plan.

EXHIBIT 6-3.—Participants' perception of their knowledge of evaluation topics (N = 5)



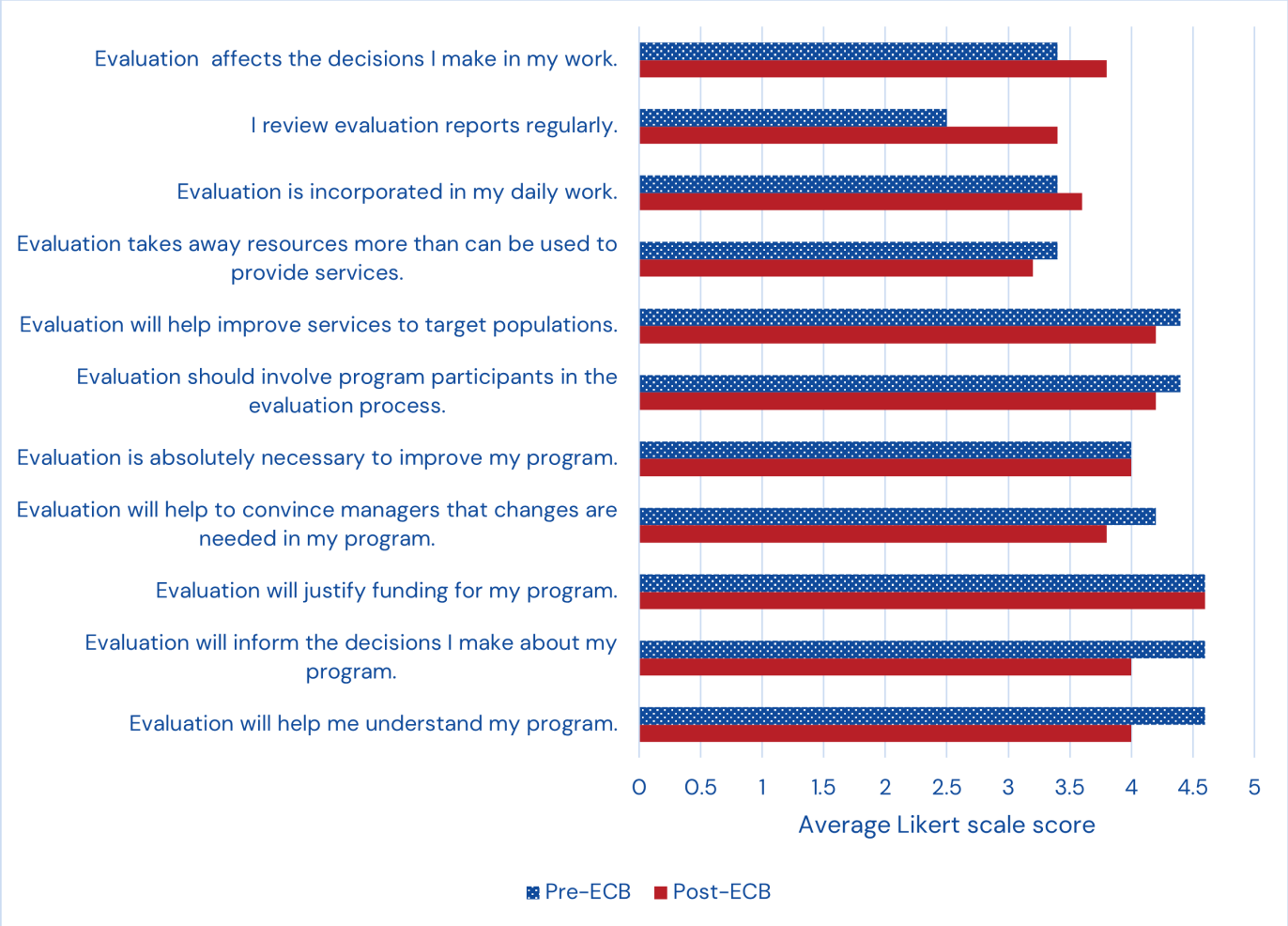
Frequency of evaluation behavior. Participants were asked how often they engaged in five evaluation behaviors in the past year, on a scale of 1 ("not at all") to 5 ("always"). Exhibit 6-4 demonstrates the increase in evaluation behavior. The largest increase was in their commitment to provide funding to carry out an evaluation or to hire an external evaluator.

EXHIBIT 6-4.—Participants' use of evaluation behavior and evaluation-related skills (N = 5)



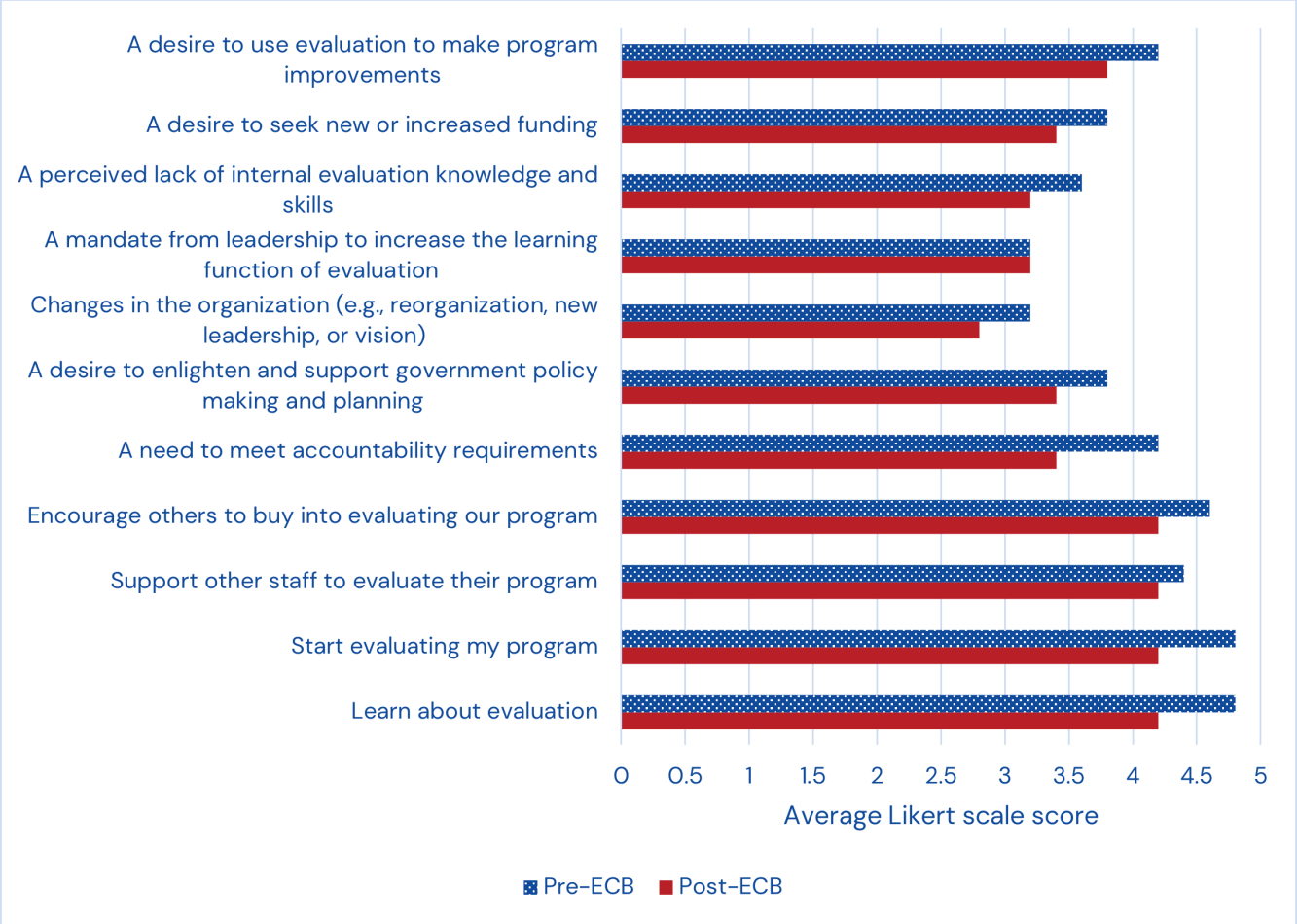
Attitudes toward evaluation. ECB participants rated their agreement with 11 statements about evaluation. For 4 of the 11 items, changes from pre to post indicated more positive attitudes toward evaluation (including 1 reverse-scored item due to survey item wording), with the largest positive change associated with the statement "I review evaluation reports regularly" (exhibit 6-5). There was no change in attitudes between pre- and post-surveys for two items, and there were five items for which attitudes toward evaluation were more negative on the post-survey than the pre-survey.

EXHIBIT 6-5.—Participants' attitudes toward evaluation (N = 5)



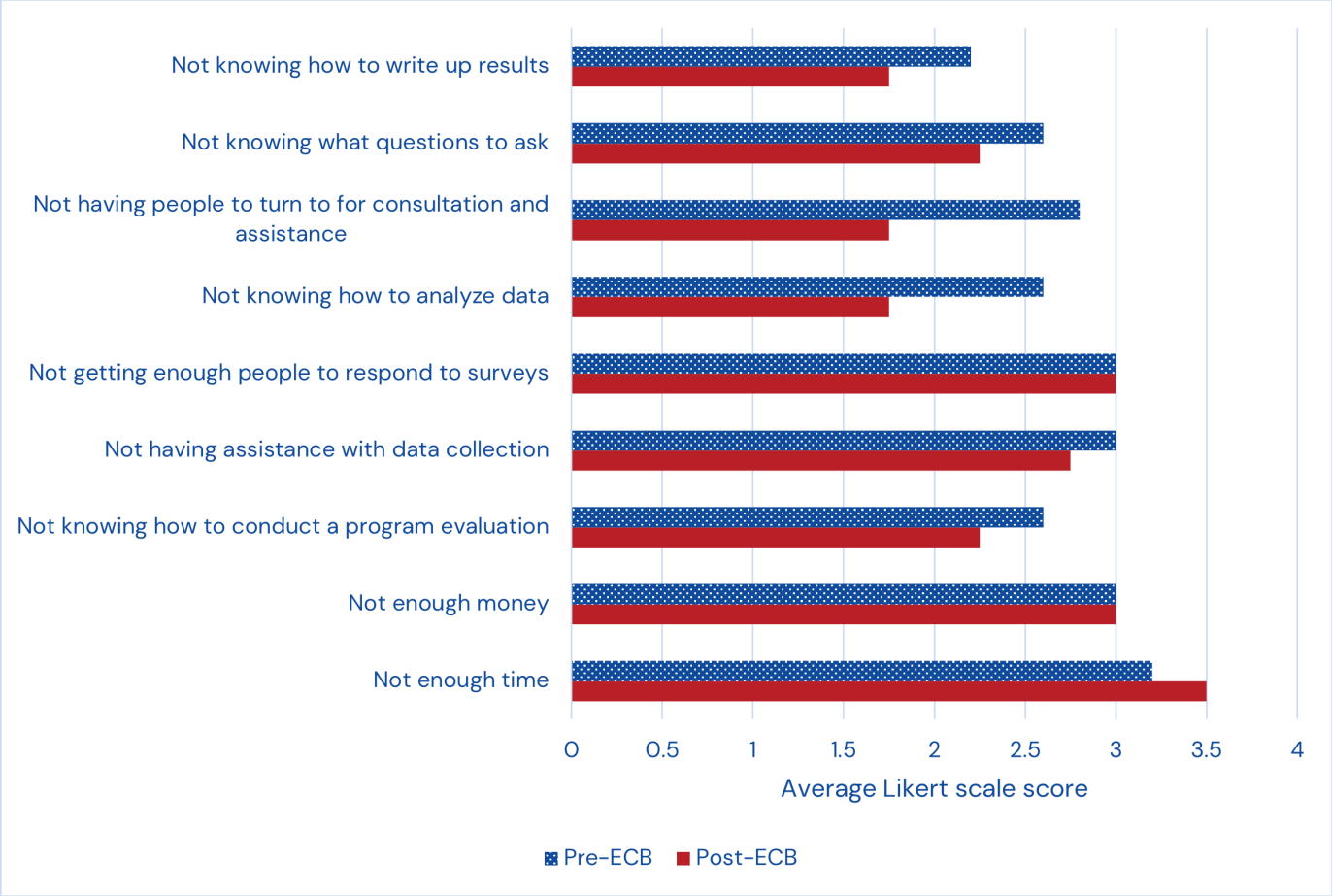
Motivation to conduct evaluation. Participants were asked to rate the importance of various reasons why they may engage in evaluation activities on a scale from 1 to 5 with 5 indicating highest perceived importance. Before the ECB series, the most highly rated motivations for conducting evaluation were: to encourage others to buy into evaluating their program; to learn about evaluation; and to start evaluating their program (exhibit 6-6). After the ECB series, organizations' motivation to conduct evaluation or engage with evaluation generally seemed to decrease across all but one of the statements.

EXHIBIT 6-6.—Participants' motivations to conduct evaluation



Barriers to evaluation. Participants were asked to report the extent to which they experience 9 specific barriers to evaluation, on a scale from 1 (not at all) to 5 (always). Participants reported a decrease in six barriers including "not knowing how to analyze data" and "not knowing how to conduct a program evaluation." There was no change for two barriers and an increase for one barrier ("not enough time"). The biggest barrier to evaluation pre- and post-ECB was not having enough time to conduct evaluation (exhibit 6-7).

EXHIBIT 6-7.—Barriers to evaluation



Discussion and Lessons Learned

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 State and National 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-supported recovery coaching programs as well as findings from the evaluation capacity building delivered to participants in the recovery coaching evaluation. This chapter summarizes the high-level findings, discusses these findings, and shares lessons learned in the process of conducting the evaluation.

Findings on Program Implementation

Recovery Coaching Models, Activities, and Services

Overall, organizations' recovery coaching models incorporated similar components to meet the needs of their participants.

Lived experience was widely seen as a crucial pillar of organization recovery coaching models. All organizations described the importance of lived experience as a key aspect of recovery coaching. However, there was variation in the degree to which recovery coaches had lived experience, with some recovery coaches having firsthand lived experience with an SUD, other recovery coaches having lived experience by way of having a family member or loved one with an SUD, and a few organizations taking the wide interpretation that everyone has some form of lived experience. Site visit participants also stressed the importance of lived experience, emphasizing empathy, and having experienced similar challenges as the participant. Participants described that active addiction is a lonely place, and having a recovery coach who understands their situation builds trust and rapport between coach and participant.

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 program participants (e.g., LGBTQIA2S+, Hispanic/Latino). 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 55 percent of project directors reported that sexual and gender orientations of clients were incorporated into treatment plans, and 75 percent reported that racial, ethnic, and cultural identities were incorporated into treatment plans. Project directors perceived the services to be culturally appropriate and 87 percent of program participants found that the services reflect their culture or worldview completely or very well.

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 organizations, focusing on assisting participants in building their lives to support 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 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 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 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. 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 has as part of their AmeriCorps VISTA's position description conducting community outreach and link resources.

During the COVID-19 pandemic, organizations faced challenges in providing in-person services and resources.[9] Three 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. 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. 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

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 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.

[9] Four organizations were interviewed in 2022 and all were asked about their experiences with COVID-19. The seven organizations interviewed in 2024 were not asked about COVID-19.

Organizations identified 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.

Organizations require organization-specific training, and some also require state certification training. The certification requirements for recovery coaches vary by state and not all organizations require recovery coaches to become state certified. The certification process includes a requisite number of hours of education/training, work experience, supervised work, and a certification exam. Organizations also may require organization-specific training for recovery coaches and other staff. Most director survey respondents (90 percent) reported an onboarding process for recovery coaches. Most recovery coaches reported receiving 9 or more hours of training and 69 percent of recovery coaches found the training "very helpful."

The most important attributes and skills of recovery coaches as reported by project directors include:

- lived experience
- compassion
- ability to listen and communicate
- patience
- ability to set boundaries

Support from Recovery Coaches

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 activities and supports that create community and belonging (known as ***affiliational support***), such as recovery-friendly social events and NA/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 organizations have groups specifically designed to help participants overcome trauma.

Challenges for Recovery Coaches and Opportunities for Support

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 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 themselves despite the 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.

Monitoring and oversight plans help recovery coaches to get through the challenges of their work. Four organizations 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. Interviews with coaches revealed the benefits they perceive of regular opportunities to meet with and support one another through the challenges they face in their work.

Perceived Outcomes

Organizations

Organizations reported improved organizational capacity to provide services, leveraging grant support, and collaborating with partners and community resources. Project directors from all organizations agreed that their programs have the organizational capacity to provide services. The interviews with project directors corroborated the survey results. Organizations reported seeing 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 one organization's scaling of recovery coaching to three new states.

Project directors from all organizations agreed that their programs can leverage grant financial support. They receive additional funding from private and public (including federal) organizations. The organizations also agreed that their programs collaborate with partners, organizations, and community resources. As discussed previously, all 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 85 percent of recovery coaches reported that their confidence, self-esteem, and self-management have increased since becoming a coach. Coaches also reported that their ability to help individuals with opioid addiction and their own ability to stay in recovery has increased. Overall, recovery coaches received 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 them reflect and maintain accountability in their 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 them stay in recovery and gives them 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 recovery capital reported by participants varied by the type of internal or external support. There was a varied degree of agreement across the 11 recovery capital-related survey items. Some items such as "There are more important things to me in life than using substances" had relatively high rates of agreement, while other items such as "I get the support I need from family" and "Since entering recovery I take full responsibility for my actions" have large proportions of ambivalent (neither agree nor disagree) responses. Some items had more disagreement responses, such as "I am making progress on my recovery journey." The findings suggest that recovery capital captures a breadth of internal and external resources that are important to capture individually (and not just in summary) to understand how each type of internal or external support can manifest differentially within this population.

The more hours spent weekly with a recovery coach is associated with a large increase in recovery capital. Results suggest a significant association in which participants that self-report spending 9–16 hours/week with their recovery coach had on average a 1-point higher mean recovery capital score than those who spent less than 1 hour/week with their coach (b = 1.01, std. error = 0.47, p-value = 0.03), even after adjusting for confounding by gender. Given the range of recovery capital scores, this is considered a large effect.

Just over half of program participants regularly attend physical or behavioral health services. Fifty-six percent of participants attend services daily or at least once per week. Given other findings in this evaluation highlighting that nine of the eleven organizations used partnerships to refer clients to auxiliary care, including medical care (e.g., therapy), the regular experience of services by program participants may indicate some success of these partnerships in helping to provide holistic care. More examination is needed to assess whether those that do not attend services daily (including the 13 percent that report never attending services) represent a gap between needs and services received.

Most participants report not having used substances in the last 30 days. Eighty-four percent of program participants said they did not use drugs, alcohol, or opioids in the last 30 days. It was unclear whether the remaining 16 percent of participants received harm-reduction services as part of their treatment. Future assessments may benefit from further disentangling any reported substance use.

More than 95 percent of participants would recommend the program. Almost all participants reported satisfaction with their program and would recommend it to others. Seventy-four percent rated the quality of the services received through the recovery coach specifically as "good" or "excellent," and future assessments may include follow-up probes for those who are less satisfied to give additional feedback.

Evaluation Capacity Building

Participant surveys after each of the 12 hour-long sessions on evaluation topics ranging from logic models to interpreting data suggested high average satisfaction with the sessions. A persistent perceived barrier to conducting evaluation was **not having enough time for evaluation**, which suggests program directors and staff may benefit from hiring external consultants or additional staff to undertake evaluation-specific activities. Pre-post ECB curriculum surveys suggest some expected and unexpected changes in attitudes about, and motivations for, conducting evaluation. For example, while respondents report reviewing evaluation reports more regularly, there was decreased belief that evaluation will help them to understand their program. While the small sample of only five participants allows for limited interpretation of findings, the findings may suggest a need for more tailored consultation with each organization to pinpoint how their specific objectives can be assessed by evaluation, and how evaluation findings in turn can be used to improve their programs.

Discussion of Findings

Recovery coaching is a promising substance use treatment approach that needs more examination in its implementation and associated outcomes. This study's purpose was to deepen understanding of AmeriCorps projects' implementation of recovery coaching services and to add to the dearth of evidence on its associations with positive outcomes for coaches and program participants. This project was exploratory in primarily seeking to characterize the participating organizations; their programs; and the experiences of their directors, coaches, and program participants. The resultant smaller data sample and vulnerability to biases such as self-selection bias and non-response bias may limit the generalizability of the findings. Nonetheless, rich mixed-methods data revealed common themes and variability across programs, and this report highlighted those key findings for future research to build upon.

In general, this evaluation documented the recovery coaching programs that were successful in many ways. They were implemented across diverse regions and for diverse, and challenging-to-treat target populations. Organizations leveraged paid staff, AmeriCorps State and National members, and VISTAs to support the programs by providing direct services and/or contributing to other organizational activities. Notably, interviews, focus groups, and surveys with coaches, project directors, and program participants showed the many benefits of recovery coaching. Holistic care and the treatment of individuals in recovery as whole persons stood out as an instrumental feature and benefit of the programs. Organizations were versatile in engaging in partnerships to help provide a range of services or referrals that could include, for example, behavioral therapy, art therapy, yoga, nutritional counseling, and physical exercise, which is important for reducing substance use and improving outcomes (Breslin et al., 2003).

Culturally appropriate services also recognize help seekers at the individual level. A client's culture can influence the nature and expression of substance use, coping styles, and stigma, and substance use treatments are more effective when they incorporate these culture-driven facets of recovery (La Roche & Christopher, 2009; SAMHSA, 2006). Most project directors, coaches and program participants perceived recovery coaching services as culturally appropriate. While this evaluation did not seek to assess whether these integrations of culture were associated with benefits, existing evidence suggests culturally competent treatment practices are important for substance use treatment adherence and program completion (SAMHSA, 2006). Successful treatment programming via culturally competent treatment practices may also carry health equity implications; for example, older Black Americans are less likely to finish their course of substance use treatment compared to their White or Hispanic American counterparts (Grooms & Ortega, 2022) and the implementation of holistic, culturally appropriate care may improve treatment of populations disproportionately affected by poorer substance use treatment outcomes.

The programs captured by this evaluation reached diverse geographical regions and populations of focus. Future research and evaluation efforts should continue to assess whether recovery coaching programs equitably reach subpopulations. Existing evidence has shown, for example, that Black and American Indian/American Native populations are less likely to seek substance use treatment compared to non-Latino White populations (Acevedo et al., 2018). Monitoring and supporting the equitable accessibility of recovery coaching programs will be critical to address the persistent and wide-reaching epidemic of substance use disorders.

Lived experience was another cross-cutting theme in this evaluation's findings, carrying implications for recovery coach hiring requirements and practices. Clients, project directors, and coaches articulated through qualitative interviews and quantitative self-report surveys that lived experience with substance use recovery among coaches is helpful for building rapport and client engagement, which can in turn improve treatment

engagement and outcomes. However, a history of substance use can co-vary with a criminal history. Hiring requirements that perform criminal background checks can impede the hiring of otherwise qualified recovery coaches. The importance of lived experience for recovery coach programming illuminated throughout this report suggests hiring requirements should be amenable to opportunities that connect coaches with a deep, personal understanding of recovery to those who need that support.

Finally, recovery capital was a key evaluation question in this study that garnered important findings. Firstly, the study sample had a wide range in recovery capital (operationalized as a mean score of survey items drawn largely from a validated instrument). This range suggests those seeking treatment across AmeriCorps-supported organizations are varied in their perceptions of the internal and external resources that aid long-term recovery. This is not a surprising result but given empirical evidence that recovery capital predicts substance use and quality of life (Laudet & White, 2008), it serves as an important reminder that programs should account for recovery capital in addressing the gaps and needs within their target populations. Secondly, this evaluation found that the number of hours spent weekly with a recovery coach was statistically significantly associated with recovery capital scores, even after adjusting for self-reported gender. Those who spent 9–16 hours/week with a recovery coach had noticeably higher mean recovery capital scores than those who reported spending less than 1 hour with their coach. It is not yet clear whether this 9–16 hour category represents an optimal "dose" for recovery coaching as more research is needed with larger samples to replicate these findings. Additional research can also build upon these findings by operationalizing the number of hours as a continuous variable or exploring other categorical demarcations (e.g., 9–12 hours vs. 12–14 hours). However, this evaluation fills a gap in empirical evidence for the efficacy of greater time spent with recovery coaches on recovery capital and sets a foundation for more research.

A key priority to further this work and to attribute any positive outcomes to recovery coaching specifically is the 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. 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 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, de-identifying 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.

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.

In conclusion, these findings set a foundation for AmeriCorps to continue to build evidence on best practices for recovery programs and to explore how the agency mitigates SUDs and supports recovery through AmeriCorps projects. The goal is for the current findings to help set precedents for conducting evaluations of recovery programs and other similar types of programs.

Limitations

The findings are vulnerable to several notable biases. The small sample sizes, purposive sampling procedures, and self-selection bias (along with lack of data on those who were recruited but declined to participate) limit our ability to assess the representativeness of our data, and also limit our ability to generalize study findings. Survey questions were generated for the current study's purposes and findings may lack external validity; one exception was the use of the validated BARC-10 (Vilsaint et al., 2017) in informing this study's 11-item survey to measure the program participants' self-reported recovery capital. Despite these limitations, rich mixed-methods data revealed common themes and variability across programs, and this report highlights those key findings for future research to build upon.

Lessons Learned About Conducting Evaluations of Recovery Coaching Programs

This mixed-methods study gathered data from focus groups, interviews, and self-report surveys with a range of collection methods such as in-person site visits, virtual site visits, paper surveys, and digitally-distributed

surveys. This section briefly highlights some of the key lessons learned that may be applied to future evaluation endeavors with recovery coaching programs or with populations receiving treatment for SUDs.

Participant recruitment was challenging and sample sizes were small. The response rates for the recovery coach and program participant surveys were low, and unable to be accurately determined as the majority of surveys were distributed directly by the organizations. Sample attrition and low response rates are known barriers in the substance use research space, and these challenges were present in this specific evaluation. The necessity of recruiting 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 highlighting 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 administer study procedures (e.g., distribute surveys). Alternatively or complementarily, 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.

Concerns about confidentiality should be addressed early in the evaluation process and in numerous ways. In a similar vein to the recruitment challenges noted above, 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.

Flexibility with data collection methods is important. Virtual site visits were used as an adjustment to pandemic-related restrictions for in-person site visits. Virtual options were also given to organizations later in the evaluation, even after the restrictions were lifted. Sometimes, in-person site visits were supplemented by virtual interviews/focus groups when participants' schedules were not amenable to the in-person interview times. Session durations were sometimes shortened to accommodate potential participants' availability. Such instances of flexibility allowed more participation and the inclusion of more voices in the data that informed our findings. Broadly, flexibility in scheduling site visits to reflect the organization's availability is also helpful for maximizing participation; for instance, project directors were able to identify days/times that were opportune for the largest gathering of potential participants, and data collection benefitted by incorporating the insights of those who work at the organizations.

Optimize each encounter with participants to achieve as many data collection goals as possible. This evaluation included surveys and focus groups/interviews. It was beneficial to distribute paper versions of the surveys at the time of focus/groups interviews to maximize response rates. Time already set aside by participants to do study-related activities (i.e., showing up for the scheduled focus group) was optimal for performing other data collection activities. This included compensation so that participants were handed both a paper survey and a gift card code, to create an immediate compensation that incentivized participation. The opportunity to turn in surveys directly to study staff also minimized participants' confusion or concerns about what to do with surveys and may have abated concerns about program staff/other program participants having access to their confidential survey responses.

Explore both within- and across-site differences. As noted in the study limitations in the Methods and Data Sources chapter, some organizations had multiple sites and the study team only visited a subset of the locations as specified by the organization. For organizations with multiple sites, there was often variation in the target populations and recovery coach approaches and services offered by each site; however, survey and site visit data were analyzed at the organization level and did not examine possible differences within organizations with multiple sites. Future studies could explore implementation and outcomes both within and across organizations offering a more nuanced understanding of successes, challenges, and outcomes for different implementation contexts.

References

Acevedo, A., Panas, L., Garnick, D., Acevedo-Garcia, D., Miles, J., Ritter, G., & Campbell, K. (2018). Disparities in the treatment of substance use disorders: Does where you live matter? *The Journal of Behavioral Health Services & Research*, *45*(4), 533–549. https://doi.org/10.1007/s11414-018-9586-y

American Society of Addiction Medicine. (2016). *Opioid addiction treatment: A guide for patients, families and friends*. http://eguideline.guidelinecentral.com/i/1275542-asam-opioid-patient-guide-2020/0?

Bassuk, E. L., Hanson, J., Greene, R. N., Richard, M., & Laudet, A. (2016). Peer-delivered recovery support services for addictions in the united states: A systematic review. *Journal of Substance Abuse Treatment, 63*, 1–9. https://doi.org/10.1016/j.jsat.2016.01.003

Boisvert, R. A., Martin, L. M., Grosek, M., & Clarie, A. J. (2008). Effectiveness of a peer-support community in addiction recovery: Participation as intervention. *Occupational Therapy International, 15*(4), 205–220. https://doi.org/10.1002/oti.257

Breslin, K. T., Reed, M. R., & Malone, S. B. (2003). An holistic approach to substance abuse treatment. *Journal of Psychoactive Drugs*, *35*(2), 247–251. https://doi.org/10.1080/02791072.2003.10400006

Center for Substance Abuse Treatment (2009). *What are peer recovery support services?* [HHS Publication No. (SMA) 09-4454.] Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Centers for Disease Control and Prevention [CDC]. (2023a). Drug overdose deaths: Drug overdose deaths. https://www.cdc.gov/nchs/hus/topics/drug-overdose-deaths.htm

Centers for Disease Control and Prevention [CDC]. (2023b, August 22). *Other drugs*. https://www.cdc.gov/overdose-prevention/about/polysubstance-overdose.html?CDC_AAref_Val=https://www.cdc.gov/drugoverdose/deaths/other-drugs.html

Centers for Disease Control and Prevention [CDC]. (2023c). *Fentanyl*. https://www.cdc.gov/overdose-prevention/about/fentanyl.html?CDC_AAref_Val=https://www.cdc.gov/opioids/basics/fentanyl.html

Centers for Disease Control and Prevention [CDC]. (2023d). What you should know about Xylazine. https://www.cdc.gov/overdose-prevention/about/what-you-should-know-about-xylazine.html?CDC_AAref_Val=https://www.cdc.gov/drugoverdose/deaths/other-drugs/xylazine/faq.html

Eddie, D., Hoffman, L., Vilsaint, C., Abry, A., Bergman, B., Hoeppner, B., Weinstein, C., & Kelly, J. F. (2019). Lived experience in new models of care for substance use disorder: A systematic review of peer recovery support services and recovery coaching. *Frontiers in Psychology, 10,* 1–12. https://doi.org/10.3389/fpsyg.2019.01052

Gagne, C. A., Finch, W. L., Myrick, K J., & Davis, L. M. (2018). Peer workers in the behavioral and integrated health workforce: Opportunities and future directions. *American Journal of Preventive Medicine, 54*(6S3), S258–S266. https://doi.org/10.1016/j.amepre.2018.03.010

Grooms, J., & Ortega, A. (2022, April 29). Racial disparities in accessing treatment for substance use highlights work to be done. *USC Schaeffer*. https://healthpolicy.usc.edu/evidence-base/racial-disparities-in-accessing-treatment-for-substance-use-highlights-work-to-be-done/

Kamon, J., & Turner, W. (2013). Recovery coaching in recovery centers: What the initial data suggest – A brief report from the Vermont Recovery Network. Evidence-Based Solutions. https://legislature.vermont.gov/Documents/2014/WorkGroups/House%20Human%20Services/Bills/S.295/Witness%20Testimony/S.295~Mark%20Ames~Recovery%20Coaching%20Report~4-15-2014.pdf

Kawasaki, S., Francis, E., Mills, S., Buchberger, G., Hogentogler, R., & Kraschnewski, J. (2019). Multi-model implementation of evidence-based care in the treatment of opioid use disorder in Pennsylvania. *Journal of Substance Use & Addiction Treatment, 106*, 58–64. https://doi.org/10.1016/j.jsat.2019.08.016

La Roche, M. J., & Christopher, M. S. (2009.) Changing paradigms from empirically supported treatment to evidence-based practice: A cultural perspective. *Professional Psychology: Research and Practice, 40*(4), 396–402.

Laudet, A. B., & White, W. L. (2008). Recovery Capital as prospective predictor of sustained recovery, life satisfaction, and stress among former poly-substance users. *Substance Use & Misuse*, *43*(1), 27–54. https://doi.org/10.1080/10826080701681473

Laudet, A. B., Harris, K., Kimball, T., Winters, K. C., & Moberg, D. P. (2016). In college and in recovery: Reasons for joining a collegiate recovery program. *Journal of American College Health, 64*(3), 238–46. https://doi.org/10.1080/07448481.2015.1117464

O'Conner, R., Perrins, S., Spinney, S., Holbrook, B., Shepard-Moore, H., Rakes, E., MacDonald, A., Fitzgerald, K., & Sarwana, M. (2023). *A bundled evaluation of AmeriCorps-supported recovery coach programs: Preliminary findings*. ICF. https://americorps.gov/sites/default/files/document/AmeriCorps%20Recovery%20Coaching%20Cohort%201%20Report%20v2.pdf

Sanders, L. M., Trinh, C., Sherman, B. R., & Banks, S. M. (1998). Assessment of client satisfaction in a peer counseling substance abuse treatment program for pregnant and postpartum women. *Evaluation and Program Planning, 21*(3), 287–296. https://doi.org/10.1016/S0149-7189(98)00018-4

Substance Abuse and Mental Health Services Administration [SAMHSA]. (2023). Harm reduction. https://www.samhsa.gov/find-help/harm-reduction

Substance Abuse and Mental Health Services Administration [SAMHSA]. (2017). *Peers supporting recovery from substance use disorders* [Infographic]. https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peers-supporting-recovery-substance-use-disorders-2017.pdf

Substance Abuse and Mental Health Services Administration [SAMHSA]. (2006). Addressing diverse populations in intensive outpatient treatment. In Center for Substance Abuse Treatment, *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment* [Treatment Improvement Protocol Series 47]. U.S. Department of Health and Human Services. https://www.ncbi.nlm.nih.gov/books/NBK64095/

Tanz, L. J., Dinwiddie, A. T., Snodgrass, S., O'Donnell, J., Mattson, C. L., & Davis, N. L. (2022). *A qualitative assessment of circumstances surrounding drug overdose deaths during the early stages of the COVID-19 pandemic*. State Unintentional Drug Overdose Reporting System (SUDORS) data brief. Centers for Disease Control and Prevention. https://www.cdc.gov/overdose-prevention/?CDC_AAref_Val=https://www.cdc.gov/drugoverdose/pdf/SUDORS-COVID-DataBrief-22.pdf

The White House. (2022, March 2). FACT SHEET: Addressing addiction and the overdose epidemic. https://www.whitehouse.gov/briefing-room/statements-releases/2022/03/01/fact-sheet-addressing-addiction-and-the-overdose-epidemic/

U.S. Department of Housing and Urban Development. (2015). Definition of chronic homelessness. HUD Exchange. https://www.hudexchange.info/homelessness-assistance/coc-esg-virtual-binders/coc-esg-homeless-eligibility/definition-of-chronic-homelessness/#:~:text=The%20definition%20of%20chronically%20homeless%20is%3A,in%20an%20emergency%20shelter%2C%20and

Vilsaint, C. L., Kelly, J. F., Bergman, B. G., Groshkova, T., Best, D., & White, W. (2017). Development and validation of a Brief Assessment of Recovery Capital (BARC-10) for alcohol and drug use disorder. *Drug and Alcohol Dependence, 177*, 71–76. https://doi.org/10.1016/j.drugalcdep.2017.03.022

Zandniapour, L., Menon, R., Renier, T., & Dermanjian, S. (2020). *A promising response to the opioid crisis: CNCS-supported recovery coach programs*. Corporation for National and Community Service, Office of

Research and Evaluation. https://americorps.gov/sites/default/files/evidenceexchange/23419_CNCS_ORE_Opioid_Report_v03_RELEASE_508_1.pdf

Appendix A. 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] 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, [Study staff email and phone contact]. 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?
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, ,[Study Staff contact email and phone].. 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, ,[Study Staff contact email and phone]. 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 B. 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,[Study Staff contact email and phone]. 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]?
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): 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?)
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 program participant 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, [Study Staff contact email and phone]. 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[Study Staff contact email and phone]. For questions regarding your rights related to this evaluation, you can contact ICF's Institutional Review Board at IRB@icf.com.

Interview Protocol

Let's begin with some brief introductions. Please tell me a little bit about yourself, including your name and role in the program.

1. 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?
2. Are you currently in recovery?
   (If yes, continue.)
   (If no, skip to question 6.)
3. In your recovery, did you receive any recovery support?
4. How does your own recovery or lived experience affect your work (e.g., relationship-building with your clients) as a [recovery coach]?
5. Can you please share the reasons you decided to become a coach with [organization name] and how long you have been with the program?
6. 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?
7. 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.

8. How has the pandemic impacted the work you are able to do? (Probe for changes in service delivery, numbers served)
9. If you have gone through a similar recovery coach program, how has this been different? (Probe for their own lived experience/recovery)
10. 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?
11. 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.
12. 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?
13. How many people are in your entire caseload? Do you feel like you can provide the support your clients need?
14. Describe how [org name] prepared or trained you to address culture and worldview in a client's treatment plan.
15. Describe how you incorporate your client's culture and worldview into the individual's treatment plan.
16. What do you do to help the individuals you work with combat opioid use disorder?

17. To what extent do you work with other coaches or medical personnel to help address the needs of individuals with opioid use disorder?
18. 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.
19. 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?
20. In what ways has being a [recovery coach] changed your own life?

    (*Probe for knowledge, attitude, and behavior.)*
21. What do you like about being a [recovery coach]?
22. What is the biggest barrier you face in your day-to-day as a [recovery coach]?
23. 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?
24. Do you maintain contact with other coaches? If so, how useful is that?
25. 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?
26. Do you have plans to use the education award? If so, how do you plan to use it?
27. Would you say that the AmeriCorps position at [organization name] is your first professional job experience?
28. Do you think this position will provide you with future job opportunities? If so, how?
29. 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, [Study Staff

contact email and phone]. For questions regarding your rights related to this evaluation, you can contact ICF's Institutional Review Board at IRB@icf.com.

Focus Group Protocol

Let's begin with some brief introductions. Please tell me a little bit about yourself. 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?

1. Please describe what it's like working with a [recovery coach]. What kind of support do you receive from your [recovery coach]?
2. How frequently do you communicate with your [recovery coach]? Do you reach out to your coach, or does the coach normally initiate communication?
3. Have you worked with the same [recovery coach] since you have been with [organization name]?
4. How has COVID impacted you seeking treatment?
5. 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?
6. In what ways could your interactions with [recovery coaches] be improved?
7. What are the most important skills for a [recovery coach] to have?
8. Describe how your [recovery coach] incorporates your culture and worldview into your treatment plan?
9. What are the most important aspects of your recovery from opioid use disorder that you hope to address with your [recovery coach]?
10. 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?
11. 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?
12. Do you attend health services, including physical or behavioral services, outside of your interactions with [organization name]?
13. Would you say that you attend more or fewer services than when you started working with [organization name]?
14. Does working with a [recovery coach] help you reduce your substance use including opioid use? If so, how?
15. How has your quality of life changed since beginning your work with a [recovery coach]?
16. If you saw someone who was struggling in recovery, would you recommend this program to that person?
17. Would you ever consider becoming a [recovery coach] yourself? Why or why not?
18. Do you have any additional feedback or insights you would like to share with us regarding the program?

Appendix C. Cohort 2 Survey Findings

Key survey findings for the seven organizations with AmeriCorps-supported fiscal year (FY) 2022 and FY 2023 projects are presented as "Cohort 2" findings in this appendix to complement the "Cohort 1" findings already published (*AmeriCorps Recovery Coaching Cohort 1 Report*).

Data Sources

Surveys

As detailed in the Methods and Data Sources chapter of this report, survey instruments 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:

- **Project director/manager surveys** assessed organizational capacity, staff recruitment, ability to leverage grant financial support, and collaboration with partners and community resources. In some instances, partners with an active role in program implementation also completed the project director/manager survey.
- **Recovery coach surveys** assessed knowledge, attitudes, and behaviors; activities and services provided; experiences with the organizations; and experiences with program participants.
- **Program participant and comparison group surveys** assessed recovery capital, attendance to physical and behavioral health services, incidence of substance use, and experiences interacting with organizations and recovery coaches.

The surveys were digitally distributed in spring 2023 to organizations that in turn forwarded the untraceable (i.e., anonymous) survey link to potential participants. The digital surveys and paper-based surveys were also distributed during in-person site visits in fall/winter 2023.

The number of surveys for each respondent group (director/manager, recovery coach, program participant, comparison group, AmeriCorps member) across the seven organizations are shown in exhibit C-1.

EXHIBIT C-1.—Number of surveys completed for each key informant group by participating organization*

Organizations	Director/Manager	Recovery Coach	Program Participant	Comparison Group	AmeriCorps Member
Align9	1	2	2	-	-
County of Washington	2	7	-	-	3
Covenant Community	5	5	11	-	-
Footprints	2	3	1	-	4
Maggie's Place	2	3	11	-	-
NYC Department of Health and Mental Hygiene	1	-	-	-	20
RHOPE	2	13	36	2	-
Total	**15**	**33**	**61**	**2**	**27**

* These are the number of valid surveys, defined as 50-plus percent complete.

Despite repeated efforts to identify viable comparison group respondents, most organizations did not have clients in recovery who were not receiving recovery coaching. As such, Cohort 2 only had two surveys for the comparison group. AmeriCorps' members surveys were largely from one organization: NYC Department of Health and Mental Hygiene.

Survey Sample

The demographic characteristics for the recovery coach and program participant respondent groups are as follows: over half of recovery coaches (64 percent) were female and were White (58 percent), and most were non-Hispanic (85 percent). The majority of recovery coaches (61 percent) were between the ages of 30 and 69. Almost one-third (30 percent) of recovery coaches were college graduates.

Of the program participants, there more male (56 percent) than female (36 percent) participants, and only one participant identified as nonbinary. More than 52 percent were White and 25 percent were Black or African American. Eighty percent identified as non-Hispanic, Spanish, or Latino/a. Forty percent of the program participants were 30–39 years old and 25 percent were 40–49 years old. The majority had a high school diploma or higher educational attainment (87 percent).

Outcome Measures

As detailed in the main report, the evaluation measured outcomes for organizations, recovery coaches, and program participants. For organizations, outcomes included organizational capacity, ability to leverage grant financial support, and collaboration with partners and community resources. For recovery coaches, outcomes assessed knowledge, attitudes, and behaviors as well as the opportunity for recovery coaches to maintain their own recovery. For program participants, outcomes examined recovery capital, attendance to physical and behavioral health services, and self-reported substance use in the past 30 days (see exhibit 2-6 for outcomes and indicators).

Findings

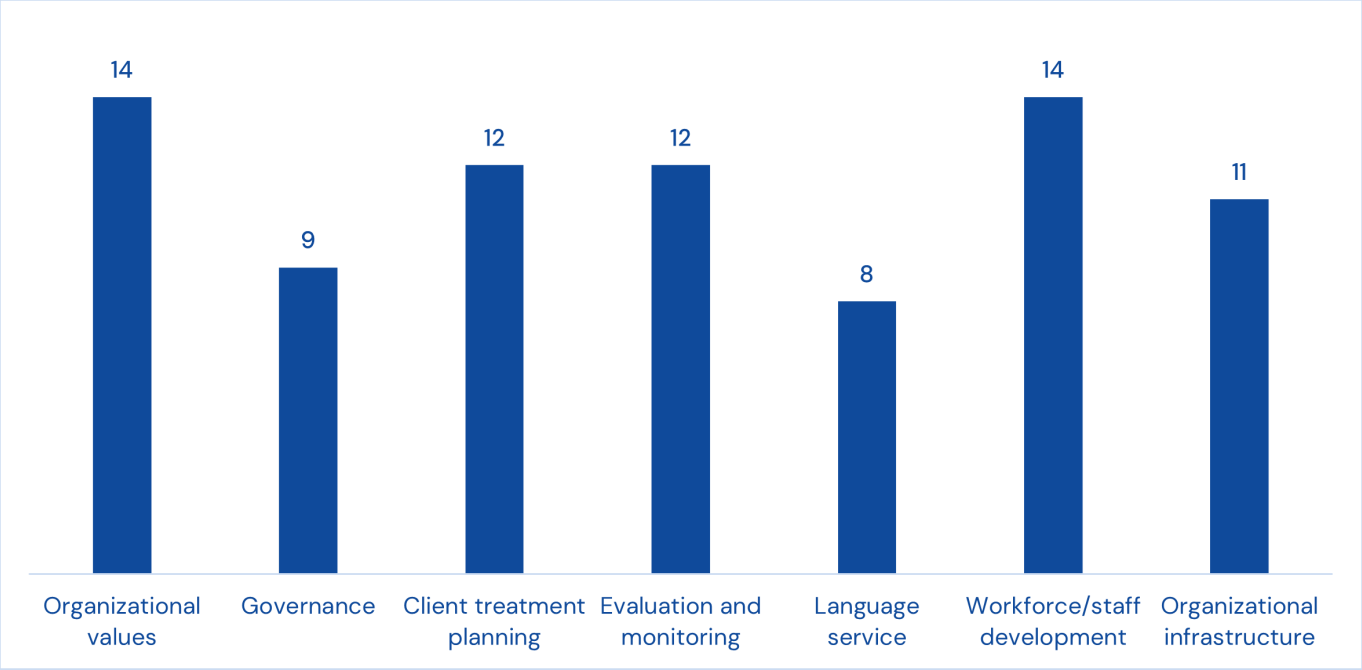
This section summarizes the survey results from Cohort 2 that contributed to the findings summarized in the final report. Since these data were included in the final analyses, the overall findings are largely the same. The findings are presented for: the recovery coach programs; recovery coaching; and program outcomes.

Recovery Coach Programs

Lived experience was an important consideration for organizations. Of the 14 program director responses for the survey item "How important is it for potential recovery coaches to possess lived experience?", all but one responded "very important." Notably, the remaining response was "very unimportant," which may suggest organizations feel strongly one way or another.

Organizations provide culturally appropriate services to their participants. Exhibit C-2 shows the number of program directors who endorsed each of the following program areas as embodying culturally responsive treatment environments. The most commonly endorsed program areas included organizational values and workforce/staff development (93 percent each), and the least endorsed program area was language services (53 percent).

EXHIBIT C-2.—Number of program directors endorsing program areas with culturally appropriate services (N = 15)

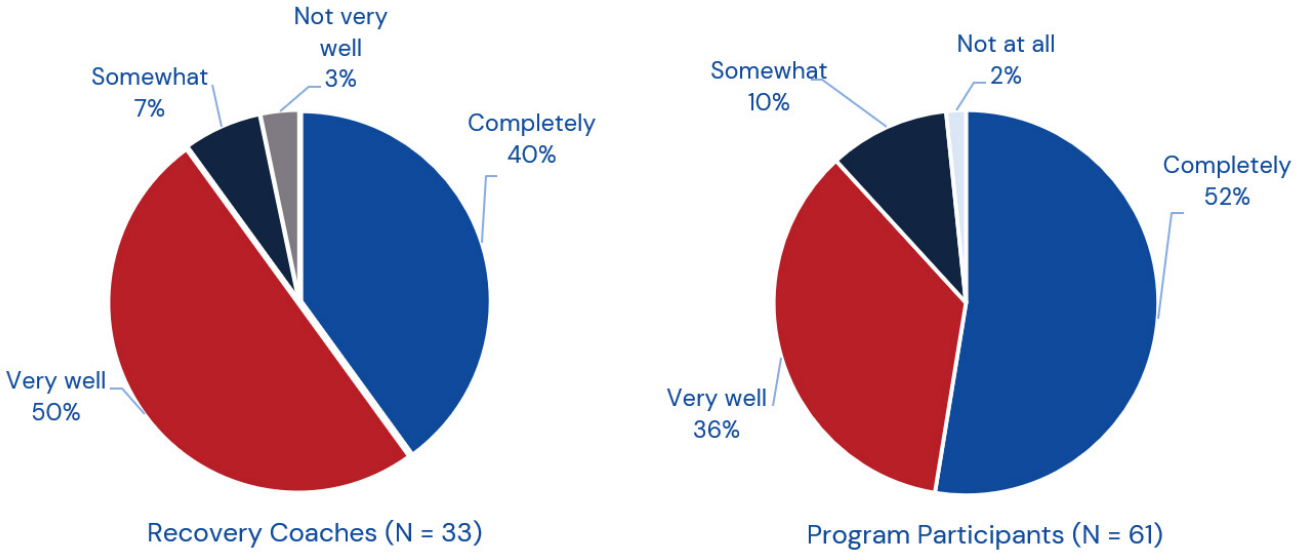


Source: Program Director survey item "In which of the following areas does the program at the [organization] offer employees or clients a culturally responsive treatment environment?"

Program directors also reported on the incorporation of various client characteristics, beliefs, and concerns into treatment plans. Sixty percent of program directors reported that each of the following factors were incorporated into treatment plans: family views on substance use and substance use treatment; treatment concerns related to cultural differences; cultural approaches to healing or treatment of substance use; and sexual and gender orientation. Sixty-seven percent of program directors reported incorporation of the following factors: English, bilingual, or multilingual fluency; current network of support; and relationship and dating concerns. Seventy-three percent said trauma history is incorporated into treatment plans. Eighty percent said work history and concerns; socioeconomic and financial concerns; community concerns; racial, ethnic, and cultural identities; family and extended family concerns; health concerns; beliefs about substance use; and beliefs about substance use treatment.

Program participants and coaches were asked the degree to which the organization's services reflect their culture and worldview. Eighty-five percent of program participants and 82 percent of coaches responded "completely" or "very well," generally demonstrating perceived alignment of culture and worldview with the services of the organization (see exhibit C-3).

EXHIBIT C-3.—Culturally appropriate treatment plans according to recovery coaches and program participants



Source: Recovery coach survey item "The treatment plans I develop with my clients reflect their culture and worldviews" with N = 3 missing responses, and program participant survey item "My treatment plan reflects my culture and worldview" with N = 2 missing responses.

Most recovery coaches have worked with the organization 5 years or less, and tend to have full-time working status. About two-thirds (67 percent) of the coaches reported full-time working status with the organization. All coaches reported having been a volunteer with the organization for 5 years or less, and one recovery coach did not respond to this question.

Most organizations have onboarding and training requirements for recovery coaches and other staff. All but one program director respondent reported having an onboarding process for recovery coaches that may include supervision policies and required training. Sixty-seven percent of program directors report offering training in group settings, 47 percent report trainings offered one-on-one, 53 percent report online training, and 60 percent report in-person training is available. Recovery coaches responded to survey questions about training and the majority of respondents (70 percent) report having completed 17 or more hours of recovery coach training from their organization. Only 3 percent report 9–16 hours, and 12 percent report 5–8 hours of training. Three percent report 1–4 hours of training and 9 percent reported not having received training. Coaches reported instructors have been from the organization (49 percent) or outside the organization (36 percent); and there lacked certainty about whether the training used a specific curriculum or manual, with 46 percent saying "yes" to a specific curriculum and 45 percent who either skipped this question or responded "don't know." All coaches who responded to the survey question on training helpfulness reported that they found the training helpful or very helpful (with N = 4 missing responses).

Not all organizations utilize monitoring and oversight, or track relapses among staff. Eighty percent of program directors reported that they have monitoring oversight plans, and 87 percent of program directors provide opportunities for recovery coaches to connect with one another, which can help staff wellbeing. Eighty percent also report tracking relapses among staff and 70 percent of recovery coaches reported

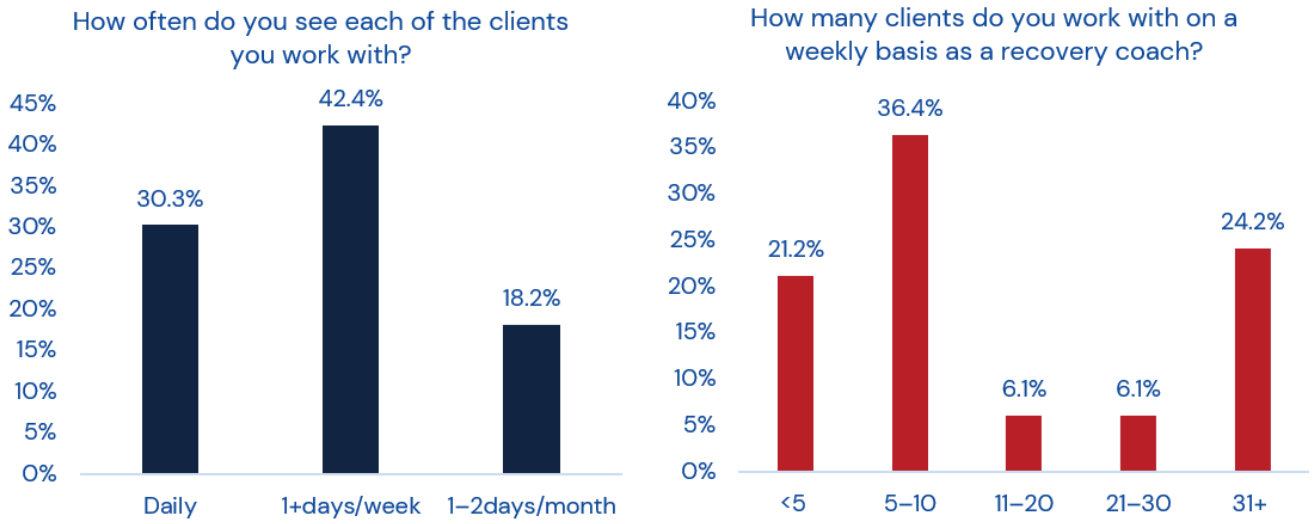
currently being in long-term recovery while 21 percent said they were not, and one individual preferred not to respond.

Recovery Coaching

This section explores the activities that recovery coaches engage in as well as the setting, modality, frequency, intensity, and duration of the services they provide, including referrals to outside organizations. Finally, the reported reasons for becoming a recovery coach and how organizations' support recovery coaches in their role are presented.

Caseload size shows a wide range among recovery coaches, and clients are typically seen at least once per week. Recovery coaches were asked how many clients they worked with each week as well as the frequency of contact (see exhibit C-4). Twenty-one percent of coaches reported seeing fewer than five clients on a weekly basis and the majority (36 percent) reported five to ten clients weekly. Notably, 24 percent of coaches reported seeing 31 or more clients on a weekly basis. Thirty percent of coaches saw their clients daily and the majority (42 percent) saw them at least once per week, while 18 percent reported once or twice per month.

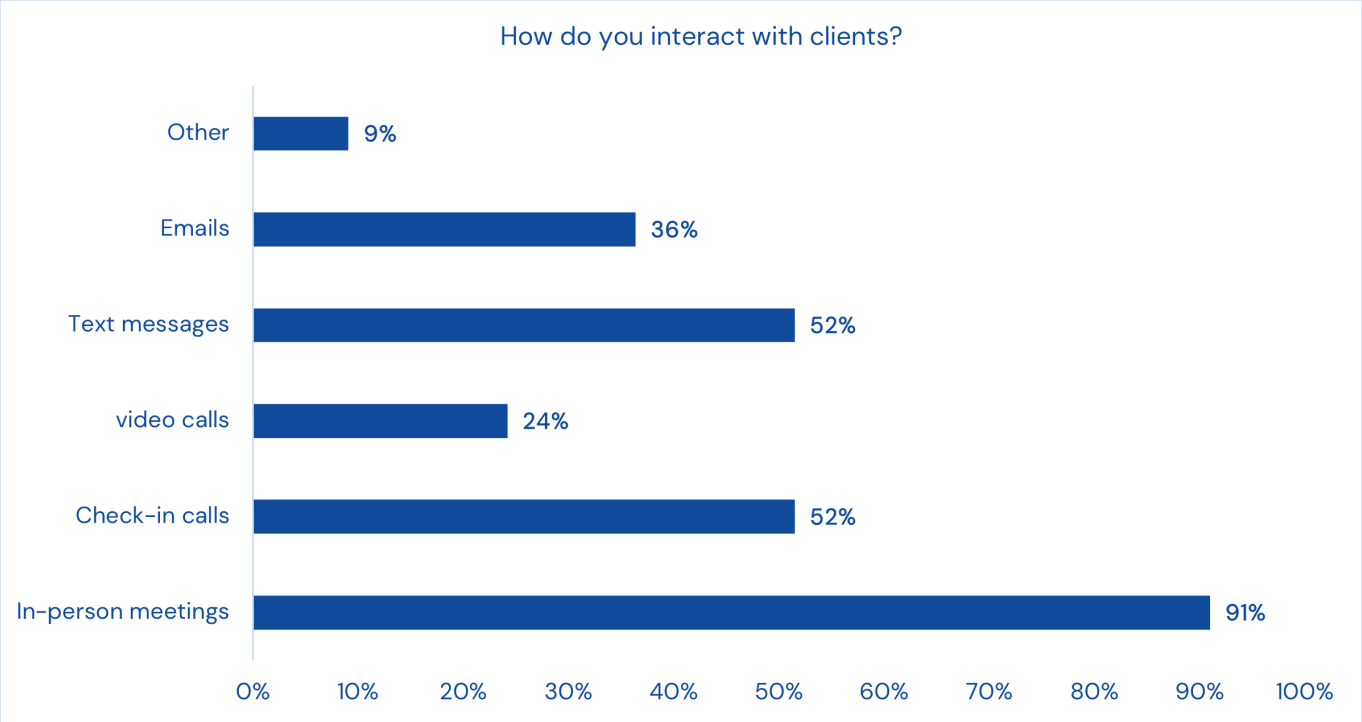
EXHIBIT C-4.—Recovery coaches (N = 33) caseload and frequency of coaching



Source: Recovery coach survey items "How often do you see each of the clients you work with?" with N = 3 missing responses, and "How many clients do you work with on a weekly basis as a recovery coach?" with N = 2 missing responses.

Recovery coaching sessions were offfered in various modes and exhibit C-5 shows the percentage of recovery coaches that offered each contact method. More than half of coaches (52 percent) reported using text messages and check-in calls, and 91 percent reported in-person meetings.

EXHIBIT C-5.—Modes of recovery coaching sessions used by recovery coaches (N = 33) (in percentages)



Source: Recovery coach survey item "How do you interact with clients? [Select all that apply]".

Recovery coaches reported a range of reasons for becoming a coach, but few reported that it was as an alternative to full-time paid employment. The most frequently reported reasons for becoming a recovery coach included the desire to help others seeking treatment from an SUD (88 percent), their own lived experience of recovery (70 percent), and to help their community (70 percent). Only 9 percent reported that they became a coach as an alternative to full-time employment, and 6 percent said "other."

Program Outcomes

This section summarizes the findings for this sample for each of the organization, recovery coach, and program participant outcomes.

Organization Outcomes

All project directors believed their organization had the capacity to provide services. In the project director/manager survey, directors were asked to rate their level of agreement on a scale from "strongly agree" to "strongly disagree" for a statement about organizational capacity ("My program has the organizational capacity needed to provide services"). All project directors agreed or strongly agreed.

Almost all project directors reported being able to leverage grant financial support. The responses to the survey item "My organization is able to leverage grant (i.e., financial) support" included 69 percent of directors who "strongly agree," 23 percent that "agree," and 8 percent who "disagree."

All project directors reported that their organization was able to collaborate with other resources. All project directors agreed or strongly agreed with the statement “My program is able to collaborate with partners, organizations, and community resources."

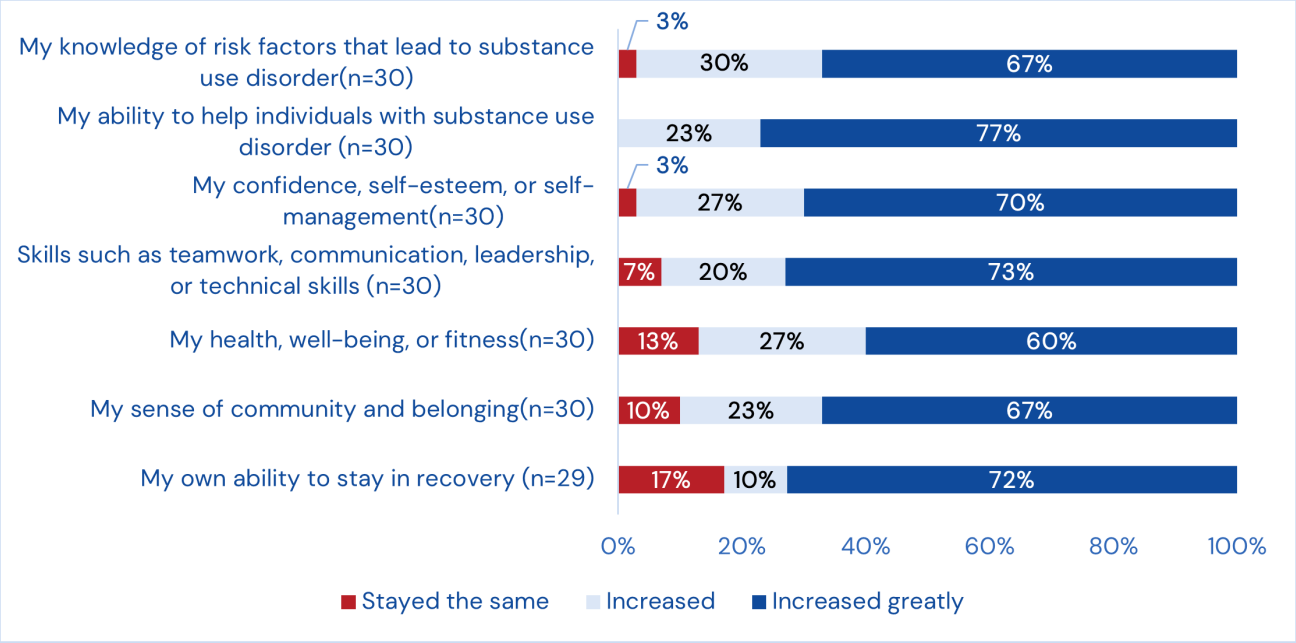
Recovery Coach Outcomes

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

Recovery coaches rated their changes in knowledge, attitudes, and behaviors since becoming a coach (exhibit C-6) on a 5-point scale ("increased greatly," "increased," "stayed the same," "decreased," or "decreased greatly"). No respondent reported "decreased" or "decreased greatly" for any of the survey items. Across the 7 items, 82–100 percent of coaches reported the knowledge, attitude, or skill "increased" or "increased greatly," indicating a strong agreement that they have experienced a multitude of benefits since becoming a recovery coach:

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

EXHIBIT C-6.—Recovery coaches' self-reported changes in knowledge, attitudes, and behaviors



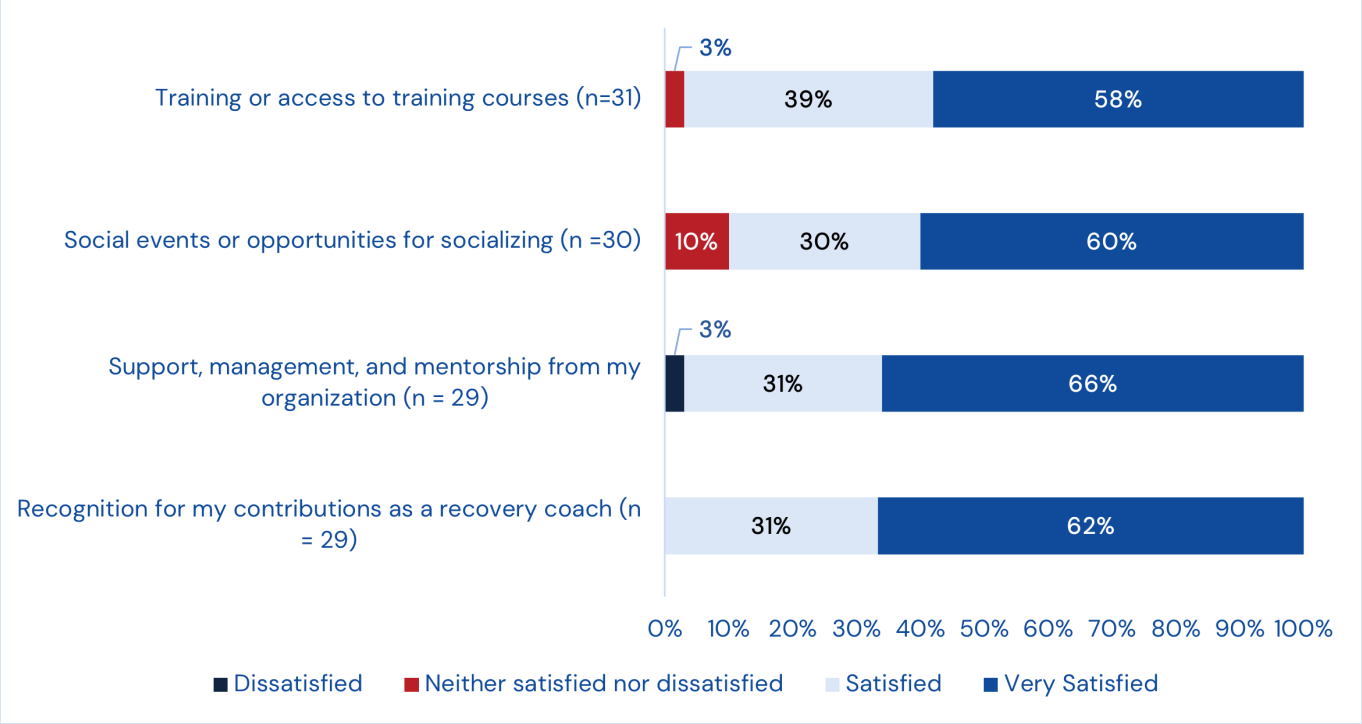
Source: Recovery Coach Survey: "Please rate the following statements based on whether each factor has increased or decreased for you since becoming a recovery coach."
Note: Totals may not add up to 100 due to rounding.

All coaches agreed or strongly agreed that they experienced satisfaction about helping individuals and the community. Coaches responded to two survey items: "How much do you agree or disagree that you get these benefits out of being a recovery coach? – Satisfaction from helping individuals with substance use disorders enter long-term recovery" and "How much do you agree or disagree that you get these benefits out of being a recovery coach? - Satisfaction from improving the health of my community." Eighty-five percent of

coaches strongly agreed that they felt satisfaction about helping individuals with SUDs and 6 percent agreed. Seventy-three percent of coaches strongly agreed that they felt satisfaction about helping to improve the health of their community while 12 percent agreed (N=2 coaches did not respond to this survey item).

In general, coaches also reported various satisfaction with aspects of being a coach. Coaches responded to survey items about: receiving recognition as a recovery coach; having support from their organization; having opportunities for socializing; and training received. Exhibit C-7 demonstrates the general satisfaction reported by coaches for each of these four survey items.

EXHIBIT C-7.—Recovery coaches' satisfaction with aspects of being a recovery coach



Source: Recovery Coach Survey: "How satisfied are you with the following aspects of being a recovery coach?"

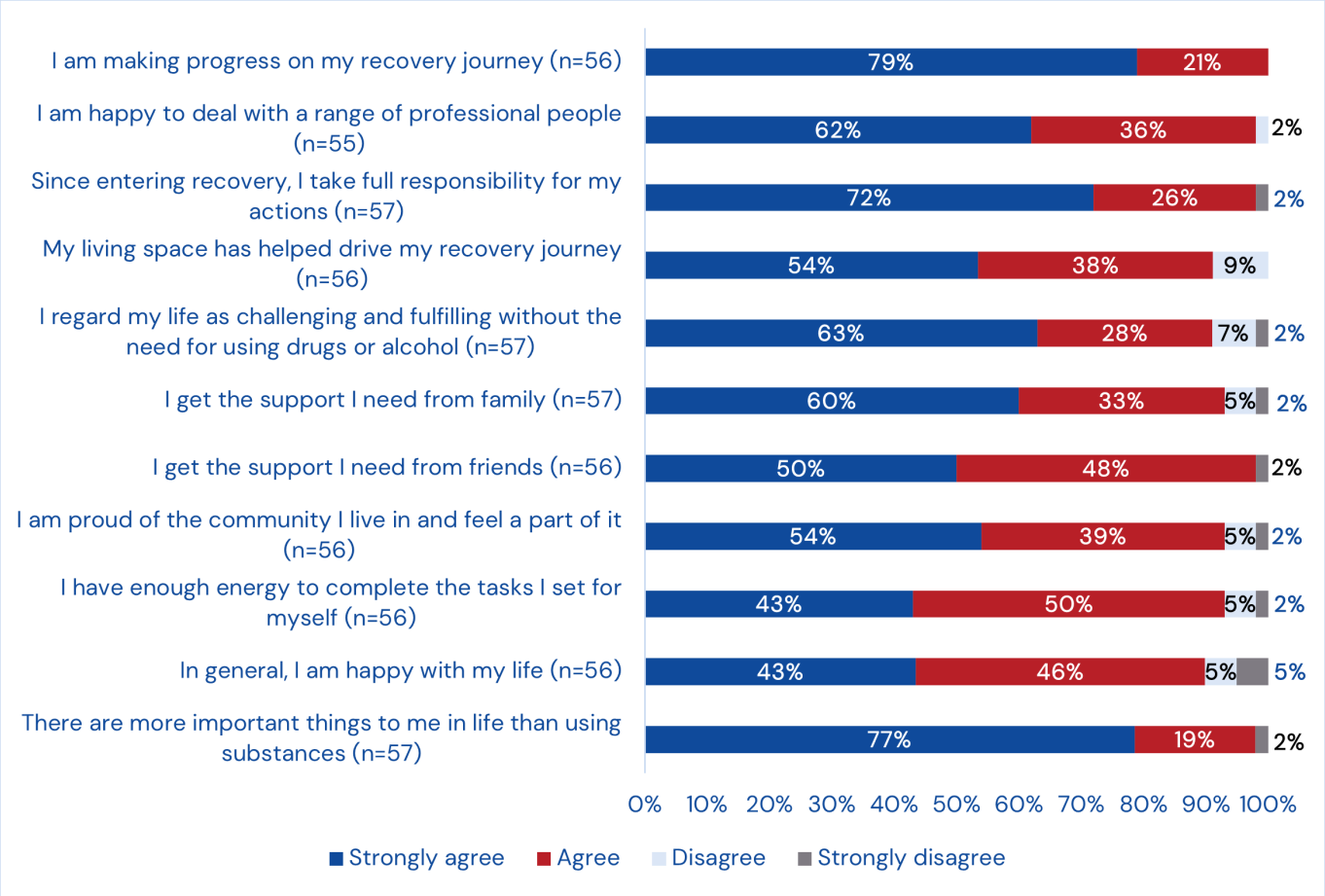
Program Participant Outcomes

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

Recovery Capital

In general, program participants had 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" (1) to "strongly agree" (5). The scores were averaged rather than summed for each respondent as a strategy to include as much data in analysis as possible when missing data were present. The mean recovery capital score was 3.4 (*SD* = 0.5) with a range of 1.6–3.9. Eighty-nine to 100 percent of participants strongly agreed or agreed to the 11 survey items. All participants believed they were making progress on their recovery journey. Exhibit C-8 shows the percentage of distribution of responses to recovery capital survey items.

EXHIBIT C-8.—Program participant responses to recovery capital survey items (in percentages)



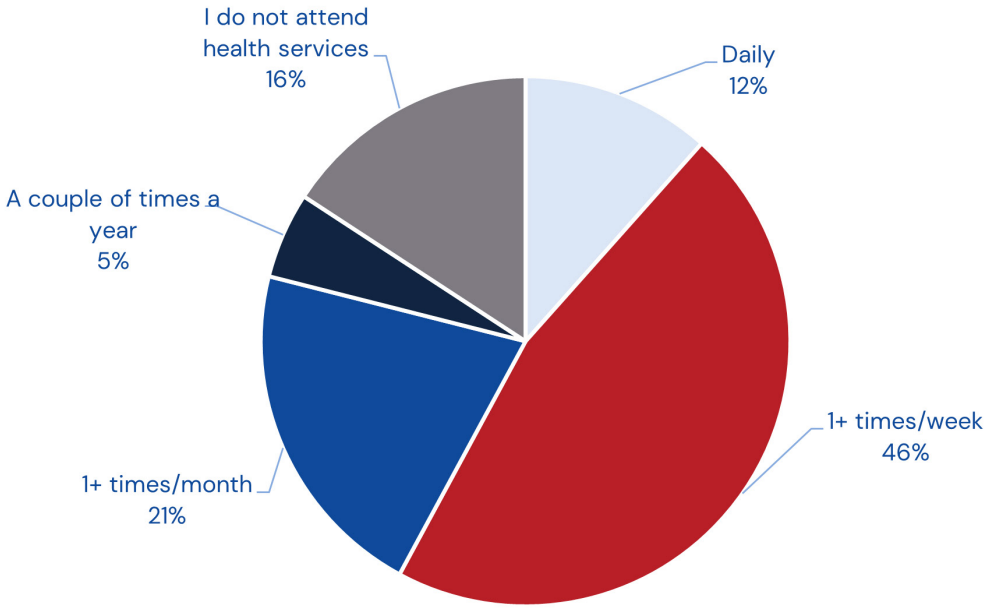
Source: Program participant survey

No statistically significant associations were found between recovery capital and time spent with recovery coaches. Regression models assessed whether the number of sessions or the duration of sessions spent with recovery coaches would be associated with recovery capital scores. No such associations were detected, which may be a function of a sample size too small to detect effects.

Physical and Behavioral Health Service Attendance

Substance use disorders often come with co-occurring physical and mental health issues. Attending physical and behavioral health services ensures that individuals receive holistic care, addressing both their substance use and any related health concerns. The survey asked program participants, " Since entering recovery, how often have you used physical and/or behavioral health services on average?" and accepted categorical responses (every day, at least once a week, at least once a month, at least once a year, I do not attend health services, and other). As illustrated in exhibit C-9, more than half (58 percent) of participants attend services at least once per week or daily, but 16 percent of participants report that they do not attend health services.

EXHIBIT C-9.—Program participants' attendance to health services (N = 61)



Sources: Program Participant Survey: "Since entering recovery, how often have you used physical and/or behavioral health services on average?" Three participants did not answer this survey question.

No statistically significant associations were found between health service attendance and time spent with recovery coaching. As with recovery capital, regression models were used to assess if more time spent in recovery coaching treatment would be associated with greater health service attendance, but no such results were found.

Substance Use

Another behavioral indicator was substance use. Program participants were asked about substance use in the past 30 days and gave a categorical response (every day, at least once a week, at least once a month, and I have not used drugs in the last 30 days). The majority of participants reported never using substances in the last 30 days (85 percent). Substance use daily, at least once a week, and at least once a month was reported by 3 percent of respondents each. It was unclear whether the participants who reported some substance use partook in harm-reduction services as part of their treatment plan.

No statistically significant associations were found between substance use and time spent with recovery coaching. Regression models did not suggest any significant association between time spent with a recovery coach and self-reported substance use in the past 30 days. However, given the low variability in reported substance use, the data likely forbade detection of effects, if any.

Satisfaction with the Program

Program participants were asked to rate their satisfaction with their program through three survey items: "How likely are you to recommend this program to another person who is dealing with addiction?"; "How do you rate the quality of services you have received with your organization?"; and "How do you rate the quality of services your recovery coach provides?" Overall, program participants expressed favorable ratings:

- Over three-quarters (77 percent) of survey respondents were “very likely” to recommend the program and 18 percent were “likely” to recommend the program. Only one respondent reported that they were neither likely nor unlikely to recommend the program, and only one individual reported "unlikely.”
- Three-quarters (70 percent) of survey respondents rated the quality of services received with their organization as “excellent” and 25 percent rated the quality as “good.” Three percent reported "fair" quality and no participants rated the program quality as "poor.”
- Almost three-quarters (74 percent) of survey respondents rated the quality of services provided by their recovery coach as "excellent," 23 percent reported "good,” and only 1 individual reported "fair" quality of services received by their recovery coach.

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