Corporation for National and Community Service

A Promising Response to the Opioid Crisis: CNCS-Supported Recovery Coach Programs

APRIL 2020

Corporation for National & Community Service
Office of Research & Evaluation
April 2020

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Citation

Corporation for National and Community Service, Office of Research and Evaluation. (2020). *A Promising Response to the Opioid Crisis: CNCS-Supported Recovery Coach Programs*. (by Lily Zandniapour, Roshni Menon, Tia Renier, and Shane Dermanjian). Washington, DC: Author.

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Acknowledgements

This study was conceived and led by the staff of the Office of Research and Evaluation (ORE) at the Corporation for National and Community Service (CNCS). A number of individuals at the Corporation for National and Community Service participated in this exploratory study and contributed to this summary report. We would like to acknowledge their contributions and thank them for their work on this important project. Tia Renier, an Eli Segal Fellow at CNCS was instrumental in the implementation of this study, leading the document review efforts and drafting of the study's findings. Dr. Roshni Menon managed the project and worked closely with the team of researchers, coordinated efforts with the AmeriCorps program, conducted data collection, and contributed to the project. Megan Johnson and Kyle Williams from University of Utah contributed to this research during their internship with the agency. They reviewed all applications and shared their document review findings. Dr. Melissa Gouge provided technical training and support to the research team on literature review, document review, and interview techniques. Shane Dermanjian, a Heinz Fellow with ORE from Carnegie Mellon University, conducted a number of key interviews, compiled qualitative findings, and finalized the report. Anthony Nerino ABD, served as a Subject Matter Expert (SME) and a reviewer. Dr. Andrea Robles reviewed the report and provided feedback. The study was designed and overseen by Dr. Lily Zandniapour and this effort was supported by the Director of the Office of Research and Evaluation, Dr. Mary Hyde, who also served as a reviewer of this report.

ORE colleagues at the AmeriCorps State and National Program contributed to this effort by providing information on the awards, grantee information, and serving as points of contact with the practitioners and service commissions. The authors would like to acknowledge and thank the 16 grantees whose work has been profiled in this report and extend special thanks to the staff of the subset of grantee organizations and their AmeriCorps national service members who served as recovery coaches/navigators and participated as key informant interviewees for this project.

Executive Summary

In 2017 the United States Department of Health and Human Services (HHS) declared a public health emergency to address the escalating number of opioid related overdoses and deaths occurring in the United States. As a result, the Corporation for National and Community Service (CNCS) drastically increased its efforts to address the epidemic, using service as a solution. CNCS has historically funded a variety of programs tackling multiple facets of substance abuse, and following the 2017 emergency declaration the organization increased its efforts to fund programs specifically targeting the opioid crisis. Recovery coaching is a particularly promising and potentially transformative strategy some programs funded by CNCS use in their interventions. This report examines 16 AmeriCorps programs funded by CNCS between 2017 and 2018 that utilize national service members as recovery coaches/navigators to examine their characteristics and approaches, draw similarities and differences amongst them, and provide recommendations for strengthening similar interventions and informing assessments and measurements of the effectiveness of these programs in the future. The report may be particularly useful for national service grantees or other opioid program operators, funders, and the research and evaluation community helping advance this field.

This research utilized a mixed methods approach consisting of conducting a review of existing literature in this field combined with a desk review of 16 programs' documents (grant applications and grantee progress reports) and a one-point-in-time primary qualitative data collection from multiple sources. Qualitative data was sourced by interviewing a purposive and diverse sample of 5 of the 16 grantees (program leads and implementers) and AmeriCorps members serving as recovery coaches/navigators. Pilot interviews were conducted during July and August of 2019 and the remaining interviews took place during September through November of 2019.

- Recovery coach models offer a holistic approach for improving the health and well-being outcomes of beneficiaries. While clinicians may provide case management, counseling or drug treatment, recovery coaches fill the gaps, and support those suffering from the Opioids addiction through the long road to recovery addressing situational, personal and medical challenges that patients typically face.
- Programs do not use a universal definition for "recovery coach", but many grantees operate using a definition that includes the concepts of being a "peer" – those with and possessing "lived experience".
- The 16 AmeriCorps programs reviewed in this study cover 13 different states and operate in an array of communities and settings. Programs help populations such as individuals in mental health and substance abuse services, veterans, those experiencing homelessness, and families in settings including shelters, recovery houses, medical facilities, clinics, and schools, and even police stations.
- Not all programs mandate that members undergo the same trainings, but many use the same established methods including Motivational Interviewing, resources from the Connecticut Community for Addiction Recovery (CCAR), *Seeking Safety*, and the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model. Recovery coaches/navigators undergo these trainings in addition to the trainings they receive as national service members.

- Three common themes emerged regarding measuring expected outcomes: reporting an increase in recovery capital, attending more physical and behavioral health services, and experiencing a decrease in substance abuse.
- Recruitment for these programs tends to be offline and through grassroots connections made across tightknit recovery networks.
- Members possessing lived experience come with their own series of challenges, but also offers unparalleled potential for relationship building with served populations.
- Members find that serving in AmeriCorps is beneficial to their own recoveries and can build capacity at organizations intervening in the opioid epidemic.

Through the analysis of program review documents and interviews, a series of programmatic and measurement recommendations were developed. Programmatically, recommendations included allowing schedule flexibility for members delivering recovery coaching services, creating supportive social networks and working environments for members, recognizing that traditional program targets and recruitment methods may not be applicable for recovery coaching programs, and adhering to proactive monitoring and surveillance plans to ensure both members and clients are on track.

Measurement and evaluation recommendations include conducting a bundled process and outcome evaluation of recovery coach models, considering a future impact evaluation of these programs that uses a quasi-experimental design to measure differences between interventions using recovery coaches and those that do not, and developing and supporting a community of practice for grantees implementing recovery coaching models to strengthen their data collection and measurement practices and to inform their program development and refinement.

Introduction

The United States continues to face an opioid epidemic. Based on the results from the 2018 National Survey on Drug Use and Health, approximately 10.3 million people aged 12 or older misused opioids in the past year – about 3.7 percent of the US population.[1] More than 700,000 people have died from a drug overdose between 1999 to 2017, and 68% of the 70,200 overdose deaths in 2017 involved opioids. The number of opioid overdoses was six times higher in 2017 than in 1999, and 130 Americans die every day on average from opioid overdoses.[2] In 2018, 10.3 million people misused prescription opioids with 2 million misusing them for the first time, and 808,000 people used heroin with 81,000 using heroin for the first time.[3]

In 2017, the United States Department of Health and Human Services (HHS) declared a public health emergency to address the escalating number of opioid related overdoses and deaths occurring in the United States.[4] Since then, healthcare providers, law enforcement agencies, and other stakeholders have worked to decrease the devastating consequences of opioid use on Americans that have escalated over the past decade.

With the increased need across America to tackle the opioid epidemic, the Corporation for National and Community Service (CNCS), the leading federal agency for national service, volunteering and civic engagement, drastically increased its efforts to address the epidemic, using service as a solution. CNCS provides grants and opportunities for thousands of Americans every year to serve local communities through its AmeriCorps and Senior Corps programs.[5] CNCS has historically funded programs tackling multiple facets of substance abuse, and following the 2017 emergency declaration the organization increased its efforts to fund programs specifically targeting the opioid crisis. These efforts were prioritized through AmeriCorps State and National grant competitions, RSVP[6] notice of Funding Opportunities, and VISTA[7] programming. In this field CNCS has worked with governor-appointed State Service Commissions, nonprofits, schools, faith-based groups, and national and local organizations and agencies.

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[1] Substance Abuse and Mental Health Services Administration. (2019). Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/. Opioids are a group of chemically similar drugs that include heroin and prescription pain relievers, such as hydrocodone (e.g., Vicodin), oxycodone (e.g., OxyContin), and morphine. In said report, opioid misuse included the misuse of prescription pain relievers or the use of heroin, and prescription pain relievers included some nonopioids because respondents could specify they misused other pain relievers that are not opioids.

[2] The Centers for Disease Control and Prevention. Understanding the Epidemic. Retrieved from (2018, December 19). https://www.cdc.gov/drugoverdose/epidemic/index.html

[3] U.S. Department of Health and Human Services. (2019, September 4). What is the U.S. Opioid Epidemic? Retrieved from https://www.hhs.gov/opioids/about-the-epidemic/index.html

[4] U.S. Department of Health and Human Services. (2018, May 23). HHS Acting Secretary Declares Public Health Emergency to Address National Opioid Crisis. Retrieved from https://www.hhs.gov/about/news/2017/10/26/hhs-acting-secretary-declares-public-health-emergency-address-national-opioid-crisis.html

[5] For more information about CNCS please visit the agency's website at www.nationalservice.gov.

[6] The Retired and Senior Volunteer Program (RSVP) provides grants to qualified agencies and organizations for the dual purpose of engaging persons 55 and older in volunteer service to meet critical community needs and to provide a high-quality experience that will enrich the lives of volunteers. RSVP is one of three Senior Corps programs administered by CNCS.

[7] VISTA refers to Volunteers in Service to America, an AmeriCorps program of the Corporation for National and Community Service.

Since FY 2017, CNCS has invested between $14 to $15 million each year in grants and projects addressing the opioid epidemic. In 2017 and 2018 alone, the agency funded 210 service projects covering all 50 states and the District of Columbia resulting in the deployment of 2,880 AmeriCorps members and Senior Corps volunteers to opioid-related grants and projects.[8] These human and financial resources supported a variety of service activities such as the safe disposal of prescription drugs, substance use prevention education, prevention of overdoses and relapse with police departments, capacity building for evidence-based treatment services, screening and assessment, and establishing state and local coalitions. In particular, one promising strategy funded by CNCS stands to be potentially transformative in its ability to combat the opioid epidemic: recovery coaching.

Purpose of Report

The purpose of this report is to provide a deeper understanding of the profile of CNCS-funded programs that utilize national service members as "coaches". This understanding is informed by an examination of the typology of these models, the larger interventions in which they are embedded, and the ways in which they track and report the activities of the recovery coaches they recruit, the types of challenges they face, and the strategies they use to overcome those difficulties. This investigation also assesses if awardees use common metrics to measure their results and how the combination of findings from this case study approach informs a future plan to assess and measure the effectiveness of these models in addressing the opioid epidemic. The report may be particularly useful for national service grantees or other opioid program operators, funders, and the research and evaluation community helping advance this field.

Background

What is a Recovery Coach?

Broadly defined, a recovery coach is a non-clinical professional who guides those suffering from substance abuse disorders through the recovery process. A recovery coach typically helps patients access care and supports them in removing barriers to recovery and/or increasing their recovery capital.[9] Recovery coaching typically augments professional medical/clinical treatment.

Why Use Recovery Coaches?

Just as there are many different paths to Substance Use Disorder (SUD) recovery, there are many different avenues of treatment. A 2017 literature review on recovery support services in the United States conducted by the Recovery Research Institute of Massachusetts General Hospital and Harvard Medical School lists recovery community centers, mutual-help organizations, recovery housing, peer-based recovery support services, and more as treatments found in scientific literature.[10] Recovery coaching, although without a single definition, fills a gap in current treatment programs for SUDs since recovery coaches use a holistic approach to recovery. In the same Massachusetts General Hospital and Harvard literature review, peer-based recovery support is described as having "respect for diverse pathways and styles of recovery, and emphasis on long-term continuity of recovery support through

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[8] Corporation for National and Community Service. (2018, December 14). National Service Responds to Opioid Crisis Fact Sheet [Fact Sheet]. Retrieved from https://www.nationalservice.gov/sites/default/files/documents/Opioid%20One-Pager_Nov2018_Updatedv3-compressed_508.pdf

[9] Recovery capital refers to a recoveree's enhanced capacity and commitment to living a sober life.

[10] Kelly, J.F. (2017). Report of Findings from a Systematic Review of the Scientific Literature on Recovery. Recovery Research Institute. Retrieved from http://www.williamwhitepapers.com/pr/dlm_uploads/Recovery-Support-Research-Lit-Review-MGH-Harvard-Recovery-Research-Institute-2018.pdf.

mobilization of personal, familial, and community supports" and connecting individuals to services "in ways not possible for conventional treatment providers"[11].

Recovery Coaches Offer a Holistic Approach
The recovery coach program models and recovery coaches provide a holistic approach for improving the health and well-being outcomes for those suffering from Opioids addiction. Given the long road to recovery and daily challenges that individuals face, the recovery coach model offers a unique approach as the model is implemented across multiple settings with coaches addressing situational, personal, and medical challenges that patients face. While clinicians may provide case management, counseling or drug treatment, recovery coaches fill the gaps, both big and small. Found in a variety of settings, recovery coaches provide one-on-one support to people in recovery, helping them identify and navigate treatment services, obtain employment and housing, access basic resources, and even establish new social networks. Human connection is critical in recovery, and recovery coaches provide the needed consistent personal contact and emotional support. A holistic approach is necessary for an individual's journey to recovery, so addressing these "outside" challenges can remove, mitigate, or ease the situational stressors that may cause a person with a SUD to relapse.

Justification
Communities currently struggle to mitigate the effects of the opioid epidemic. Most communities have insufficient resources to address the large scale of the opioid crisis, leaving a key gap in treatment settings. More vulnerable populations—the homeless, mentally ill, and lower socioeconomic classes—often fall through this treatment gap. In addition to lack of resources that recovery coaches fill, they offer a positive through line of support for patients from the point of initial contact (e.g. at an emergency room directly following a non-fatal overdose or at a police department/jail) to sustained recovery in recovery and family homes.

About This Study

AmeriCorps conducted two rounds of funding in 2017 and 2018 to address the opioid epidemic. Among grants awarded in this priority area, a total of 16 organizations[12] proposed the use of AmeriCorps members as recovery coaches to help those suffering from addiction to opioids and pain management prescription drugs to get on the path to recovery and health.[13] This study examines the 16 recovery coach models funded by the agency during this period in an effort to learn more about this strategy and the use of national service members as recovery coaches and navigators to combat this epidemic.

[11] Valentine, P. (2010). Peer-based recovery support services within a recovery community organization: The CCAR experience. In J. F. Kelly & W. L. White (Eds.), Addiction Recovery Management (pp. 259-279). New York, NY: Springer.

[12] Note that a subset of these grantees has multiple grants from the agency.

[13] The process of arriving at 16 organizations was as follows: ASN provided ORE with their 2017 and 2018 database and list of all their funded programs in each year (mega-charts). ORE filtered each year's mega-chart by opioid/substance abuse focus area and reviewed the executive summaries for the filtered list. If the executive summary mentioned implementing a recovery coach model, the program was moved to the case-study pile. In cases where the executive summary did not explicitly mention a recovery coach model but described a similar approach, the application was pulled from e-grants (the online grants managements system, where all grant documents including applications and progress reports are stored) and the narrative was reviewed to determine fit. This process culminated in 16 programs from both years being identified for inclusion on the list of candidates for the case studies.

Guiding Research Questions

The research questions that guided this study included the following:

- What does the current literature and research tell us about recovery coach models/programs and the evidence base behind them?
    - Are there different types of recovery coach models, and what are the characteristics and components of these models?
    - What types of trainings do recovery coaches receive, and are the trainings evidence-based?
    - How are these models connected to the larger interventions that address the opioid crisis and what does the literature suggest about best practices in this area?
    - What types of performance measures are used for these models?

- How do AmeriCorps recovery coach programs work?
    - What are the characteristics of the members grantees plan to recruit and from where are they recruited?
    - What are the characteristics of the beneficiaries and where are they located?
    - What types of activities do recovery coaches engage in and what is the setting, modality, frequency, intensity, and duration for the services they provide?
    - What have been the successes and challenges of the grantees in implementing their programs?
    - What lessons have the grantees learned in their work that might be of use to others addressing this crisis?
    - How do AmeriCorps grantees measure their performance, progress, and effectiveness? Are there commonalities across programs?
    - What is the value add of the AmeriCorps members in this model for the organizations that implement these models? For grantees? For recovery coaches themselves?

Methodology

This research utilized a mixed methods approach consisting of conducting a review of existing literature in this field combined with a desk review of program documents (grant applications and grantee progress reports) and a one-point-in-time primary qualitative data collection from multiple sources. Once the initial document review was completed, qualitative data was sourced by interviewing a purposive and diverse sample of five grantees (program leads and implementers)[14] and AmeriCorps members serving as recovery coaches/navigators. Primary data collection from grantees and members was targeted and compliant with the Paperwork Reduction Act. The primary mode of data collection from grantees, members and other key informants was via phone interviews, although a subset of interviewees supplemented the data collection by submitting written responses in addition to their participation in phone interviews.

The information included in the document review was gathered via a thorough reading and analysis of each of the sixteen program's grant applications as well as grant progress reports. Due to some projects being in the early stages of implementation, only nine of the sixteen programs had progress reports available for review. All documents related to these projects were examined for common traits and qualities of AmeriCorps recovery coach programs. To provide more grounding about the 16 projects included in this case study, a set of "one-pagers" were developed and are included in the Appendix B to this report.

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[14] The diversity of the sample was based on geographic location of the programs across the country and the level of maturity of grantee projects in terms of length of time they were in operation.

This summary report will first give a brief overview of common terms used to define recovery coaching and then examine the populations served by recovery coaches and the settings in which services are provided. In addition to utilizing AmeriCorps members as recovery coaches, some grantees' recovery coaches go into schools and community centers to conduct educational events centered on prevention and overdose response. Others plan on using members to recruit volunteers to help provide additional recovery support services. These duties, which may be beneficial, are not within the scope of this review. Instead, the focus will be on the specific individuals who provide coaching to those in recovery. Following this information, the review will detail the trainings available to equip members acting as recovery coaches and the common pillars of this service activity.

To demonstrate the reach of AmeriCorps programs in terms of whom they engage to promote long-term recovery, each program will be charted in a socio-ecological model, a common tool used by SAMHSA and public health entities. Additionally, this review will describe how each of these programs measure recovery and program success. Although this review covers a small cohort, common measurements and tracking tools will be identified. The review will also speak to the value add of AmeriCorps in recovery services.

Following the review of the available documents, findings from the interviews will be detailed. Interviews were held with five of the sixteen programs. For each program, at least a staff member involved in the administration of the program was interviewed as well as one AmeriCorps recovery coach from the program. Interviews were conducted via phone using the same interview protocol for each staff and another protocol for recovery coaches. Pilot interviews were conducted during July and August of 2019 and the remaining interviews took place during September through November of 2019.

CNCS Funded Recovery Coach Programs

The CNCS mission, "to improve lives, strengthen communities, and foster civic engagement through service and volunteering," makes the task of addressing the opioid epidemic a priority for the agency, its grantees, members, and volunteers. Over the course of their service term, national service members either provide direct services to community beneficiaries or serve in coordination or support positions within the organization or at implementation sites. Members typically leverage resources and volunteers for their sponsor or host organizations as well, adding capacity and increasing the ability of community-based organizations to achieve their mission. AmeriCorps members are best incorporated into recovery coach models because members commit to strengthening communities through service periods up to one year, leading to stronger relationships and ties within recovering communities.[15] The use of AmeriCorps members as recovery coaches actively works to extend the mission of CNCS directly into communities, using service as an avenue of recovery and expansion of recovery services for both the individual and the communities who are served.

Common Definitions Across Programs

Due to the recent origin of the recovery coach position as well as the rapidly changing opioid crisis, experts are still defining this role and related elements. As a result, the scope of who is a recovery coach and their role varies from one CNCS grantee to another. Still, the recovery field has identified some common terms that help guide this work.

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[15] Corporation for National and Community Service. What is AmeriCorps? Retrieved from https://www.nationalservice.gov/programs/americorps/what-americorps.

Defining Recovery Coaches

As mentioned previously, there is no singular definition of recovery coach. However, there are commonalities among the various definitions used by grantees. Some grantees utilize the Substance Abuse and Mental Health Services Administration (SAMHSA) definition of recovery coach. Per the SAMHSA definition, recovery includes addressing an individual's health, home, purpose, and community needs.[16] SAMHSA notes recovery coaches are "non-professional" and "non-clinical", meaning coaches do not duplicate or replace roles such as therapists, social workers, and clinicians. Instead, recovery coaches fill the gap between family/friend support and professionals. Grantees also heavily rely on two other terms when referencing a recovery coach: Peer Recovery Support and Lived Experience.

"Peer" is the most commonly used concept among recovery coach definitions. The term is used to describe the connection between the recovery coach and the individuals they serve. In this instance, peer recovery coaches often share similar characteristics with those in the target population. Previous graduates of a recovery service program, and those with an understanding of the recovery community tend to be recruited as recovery coaches. In addition, the term peer, in this setting, may refer to someone who is of a similar age or background, such as a veteran. The definition of peer varies from grantee to grantee and does not require that the recovery coach be similar in age or other demographic types.

"Lived Experience" is another common part of many grantees' definitions of recovery coach. Lived experience refers to a coach's prior experience recovering from substance use disorders or perhaps living in a family that is impacted by SUD. Grantee applications tout the importance of lived experience because recovery coaches have the ability to empathize with those in recovery. In addition, recovery coaches bring a deeper knowledge and understanding of what it means to tackle challenges such as navigating treatment services or rebuilding a sober lifestyle. Grantees believe that recovery coaches with lived experience are more approachable or relatable than typical treatment clinicians or even those recovery coaches without lived experience. A coach who has navigated recovery is well positioned during these times to intervene and provide "living proof" that recovery is possible. They can empathize with the difficulty of recovery and motivate more effectively. They have navigated recovery resources and can help steer others through roadblocks.

[16] Substance Abuse and Mental Health Services Administration. (2019, January 30). Recovery and Recovery Support. Retrieved from https://www.samhsa.gov/find-help/recovery.

Scope of Programs with Recovery Coach Models

The scope of this review is limited to the 16 programs funded in 2017 and 2018, using AmeriCorps members to provide non-clinical recovery coaching and navigation. The presented information regarding these programs stems from review of each program's grant application and progress report, when available. The following projects listed in **Table 1** were reviewed and are referenced throughout this document as well as the number of member service years (one member service year is equivalent to one full-time AmeriCorps member) and federal funding proposed to accomplish each project:

Table 1: 2017 and 2018 Funded Recovery Coach Model Projects		
Name of Project	**Member Service Years**	**Federal Funding Amount**
Alabama Dept of Mental Health HOOP AmeriCorps (HOOP)	20	$ 276,594
CARITAS AmeriCorps (CARITAS)	17	$ 235,106
Combatting the Opioid Epidemic - Formula Submission (COEF)	15.77	$ 229,689
Detroit Recovery Project (DRP)	0 (planning grant)	$ 110,939
Harbor Homes, Inc. (HHI)	20	$ 298,640
Maggie's Place II (MP2)	20	$ 248,426
Maine RecoveryCorps (MERC)	20.54	$ 283,768
Marshfield Clinic AmeriCorps - Recovery Corps (WIRC)	20	$ 276,600
Mary Hitchcock Memorial Hospital (MHMH)	16	$ 221,279
Mercy Health (MH)	10	$ 149,280
Minnesota Recovery Corps (MNRC)	30	$ 600,000
New Jersey RecoveryCorps (NJRC)	5.29	$ 76,335
New York Peer Corps (NYPC)	20	$ 294,000
Police Assisted Addiction and Recovery Initiative (PAARI)	15	$ 283,980
Richmond Area Healthy Futures Project (RHF)	10	$ 138,186
Rio Arriba County II (RAC2)	0 (planning grant)	$ 30,000

Who Is Being Served?

Per CNCS grant applications, recovery coach models currently serve a wide range of disadvantaged populations, including:

- Individuals in mental health services
- Individuals in substance use services
- Veterans
- Women-specific programs
- Men-specific programs
- Homeless individuals
- Adolescents/young adults and their families
- Low-income individuals
- Native Americans
- Individuals with HIV/AIDS

How Many People Are Being Served?

Among CNCS funded programs, there is a wide range in the number of individuals being served. This varies with the context of who is being served and where individuals are receiving treatment. For example, through the Police Assisted Addiction and Recovery Initiative (PAARI) at affiliated police departments across Massachusetts, recovery coaches will have the ability to directly refer and place 50 or more people into treatment. At Mercy Health (MH) emergency departments in Ohio, members are expected to screen up to 16,000 patients over the course of a year, referring them to recovery services.

This wide range of individuals served is affected by the setting, as individuals with SUDs are more likely to be accessed and assessed in emergency departments rather than police departments. A program with a smaller population size like Maggie's Place II (MP2), a homeless, women-only recovery service, has a smaller group of target clients with high needs, whereas a program like the Richmond Area Healthy Futures Project (RHF) serves more individuals overall because its target population includes both the urban area of Richmond, Virginia and Virginia Commonwealth University's (VCU) collegiate community. Per police reports, from 2007 to 2015 heroin killed more people in Richmond than in any other part of the state of Virginia.

Treatment Locations and Settings

The programs studied in this review cover 13 states with two in each of the states of New Hampshire, New York, Virginia. They also represent a wide array of community types. **Table 2** details each program, their corresponding project, and the state in which they operate:

Table 2: Programs by State

Program	Project	State
Alabama Department of Mental Health (HOOP)	Alabama Department of Mental Health HOOP AmeriCorps (HOOP)	Alabama
CARITAS	CARITAS AmeriCorps (CARITAS)	Virginia
Center for Family Services	New Jersey RecoveryCorps (NJRC)	New Jersey
City of Richmond – Human Services Commission	Richmond Area Healthy Futures Project (RHF)	Virginia
Detroit Recovery Project	Detroit Recovery Project (DRP)	Michigan
Harbor Homes, Inc.	Harbor Homes, Inc. (HHI)	New Hampshire
Healthy Acadia	Maine RecoveryCorps Program (MERC)	Maine
Maggie's Place	Maggie's Place II (MP2)	Arizona
Marshfield Clinic Research Foundation	Marshfield Clinic AmeriCorps – Recovery Corps (WIRC)	Wisconsin
Mary Hitchcock Memorial Hospital	Mary Hitchcock Memorial Hospital (MHMH)	New Hampshire
Mercy Health	Mercy Health (MH)	Ohio
New York City Office of the Mayor	New York Peer Corps (NYPC)	New York
Police Assisted Addiction and Recovery Initiative (PAARI)	Police Assisted Addiction and Recovery Initiative (PAARI)	Massachusetts
Reading & Math Inc.	Minnesota Recovery Corps (MNRC)	Minnesota
Rio Arriba County	Rio Arriba County II (RAC2)	New Mexico
Rural Health Network of South Central New York	Combatting the Opioid Epidemic - Formula Submission (COEF)	New York

In grant applications, many programs discuss the need for additional recovery resources, such as recovery coaches, either by citing the rural inaccessibility to services or the increased population and demand corresponding to an urban area. **Table 3** lists the geographic identity of each project:

Table 3: Project by Geographic Identity	
Rural	Combatting the Opioid Epidemic - Formula Submission (COEF)
	Maine RecoveryCorps (MERC)
	Marshfield Clinic AmeriCorps - Recovery Corps (WIRC)
	Rio Arriba County II (RAC2)
Urban	CARITAS AmeriCorps (CARITAS)
	Detroit Recovery Project (DRP)
	Maggie's Place II (MP2)
	Minnesota Recovery Corps (MNRC)
	New Jersey RecoveryCorps (NJRC)
	New York Peer Corps (NYPC)
	Richmond Area Healthy Futures Project (RHF)
Both Rural and Urban	Alabama Dept of Mental Health (HOOP)
	Harbor Homes, Inc. (HHI)
	Mary Hitchcock Memorial Hospital (MHMH)
	Mercy Health (MH)
	Police Assisted Addiction and Recovery Initiative (PAARI)

Table 4 shows the settings in which each project operates. There are a variety of settings, but an abundance of projects administer service in homeless shelters, recovery and rehabilitation houses, medical facilities including hospitals, clinics, and mental health centers, schools, and even police stations, detention centers, and jails.

Table 4: Project Settings

Program	Setting
Alabama Department of Mental Health HOOP AmeriCorps (HOOP)	Rehabilitation centers, mental health centers, sober houses, and recovery centers
CARITAS AmeriCorps (CARITAS)	Homeless shelters and community resource centers
New Jersey RecoveryCorps (NJRC)	Police departments, recovery centers, family service centers
Richmond Area Healthy Futures Project (RHF)	College campus, community centers, jails, and hospitals
Detroit Recovery Project (DRP)	Recovery housing (for men only) and recovery resource centers
Harbor Homes, Inc. (HHI)	Recovery community centers, emergency shelters/centers, residential care facilities, and health care centers
Maine RecoveryCorps Program (MERC)	Law enforcement agencies (sheriffs' offices/police departments), mental health centers, recovery centers, community organizations, and hospitals
Maggie's Place II (MP2)	Homeless shelters and community resource center
Marshfield Clinic AmeriCorps - Recovery Corps (WIRC)	Behavioral health clinics, drug treatment centers
Mary Hitchcock Memorial Hospital (MHMH)	Health care systems
Mercy Health (MH)	Emergency departments
New York Peer Corps (NYPC)	Homeless shelters, family resource centers
Police Assisted Addiction and Recovery Initiative (PAARI)	Police departments
Minnesota Recovery Corps (MNRC)	Sober housing, recovery centers, and recovery high schools
Rio Arriba County II (RAC2)	Clinics, hospitals, community mental health centers, treatment centers, and detention centers
Combatting the Opioid Epidemic - Formula Submission (COEF)	Recovery centers and health networks, schools, and community centers

Common Trainings

In addition to general national service trainings that members receive in preparation for their service terms, grantees are responsible for preparing AmeriCorps members for their service with applicable and appropriate training for the work they will engage in as recovery coaches. Below are several training model routinely cited as the prescribed training grantees employ to prepare members to become recovery coaches.

1. **Motivational Interviewing (MI)**[17] is the most commonly used recovery intervention in which grantees train members. Training on this tool is provided to members in seven out of the sixteen programs. It is also widely used by the substance use treatment field in general. MI helps recoverees identify purpose for changing their behavior and helps shift their perspective on their need for change. MI aims to support individuals through short-term counseling (generally only one to two sessions) until an individual is ready to commit to more intense treatment or counseling. MI was created to be person-centered, fitting well with recovery coach programs where progress is driven by the individual seeking treatment. Encouraging individuals to explore their reasons for change and comparing them to their current actions, using reflective language to avoid confrontation, is how MI helps individuals realize their own path to recovery.[18] Other programs did not clearly define the dosage of this training but at MHMH, members receive 16 hours of training in MI.
2. Several of our grantees utilize the addiction recovery training resources from the **Connecticut Community for Addiction Recovery (CCAR)**[19]. CCAR offers a battery of workshops as well as intensive trainings for recovery coaches held across the country. Webinars are also offered as an online resource for those unable to attend in person. The CCAR model provides recovery coaches with tools to facilitate one-on-one goal setting in areas such as physical health, emotional health and connection to the recovery community. AmeriCorps members at both MERC and WIRC received 30 hours of this training.
3. **Seeking Safety**[20] is a recovery training program that trains non-professional individuals to help recoverees deal with co-occurring PTSD and substance use. It is an evidence-based approach which educates clients on the connection between their trauma and substance abuse, so they may develop safe coping skills. Based on a review of the grant applications, four grantees utilize this training, but it is unclear how many hours of training members receive on this strategy.
4. **Screening, Brief Intervention, and Referral to Treatment (SBIRT)**[21] is another evidence-based training used by two of the grantees. Grantees utilizing this model often place members in Emergency Departments or other places where people in crisis can go for help. Rather than taking a long-term approach, it is screening tool to identify risk for behavioral health disorders (including addiction) and provide referrals and education at the point of initial contact. Programs estimate that the initial screening takes 45-60 minutes.

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[17] Link to training resources: https://www.integration.samhsa.gov/clinical-practice/motivational-interviewing.

[18] Center for Substance Abuse Treatment. Enhancing Motivation for Change in Substance Abuse Treatment. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 1999. (Treatment Improvement Protocol (TIP) Series, No. 35.) Chapter 3—Motivational Interviewing as a Counseling Style. Available from: https://www.ncbi.nlm.nih.gov/books/NBK64964/.

[19] Link to training resources: https://addictionrecoverytraining.org/.

[20] Link to training resources: https://www.treatment-innovations.org/seeking-safety.html.

[21] Link to training resources: https://www.integration.samhsa.gov/clinical-practice/sbirt.

Other training models referenced in grantee applications include:

- Community Health Worker Training (free online training)[22]
- Virginia Commonwealth University's Peer Recovery Support Specialist Certification [23]
- McShin Foundation's 16-hour Recovery Coaching Training[24].

Comparing Common Elements of Recovery Coaching

In addition to common trainings and models used to deliver services, the 16 AmeriCorps grantees in this review share commonalities surrounding the time and duration of intervention as well as who drives service. The majority of recovery coach programs also provide referrals to additional community resources but, as will be discussed, this looks different across the board.

Timing of intervention

There is little definitive research about the ideal time to engage individuals in recovery coach services. The 16 CNCS programs vary in terms of the phases at which they provide services. After review, these phases can be categorized as either prevention, intervention or long-term recovery support.

- **Prevention** targeted programs address individuals who may be at-risk for SUD, intended to build support before opioid misuse becomes an issue. Most programs have prevention strategies as secondary tasks completed by recovery coaches via community outreach or youth education, however this is typically not the main assignment for recovery coaches. Alabama Department of Mental Health HOOP AmeriCorps (HOOP) is one program with a strong prevention focus as members are tasked with providing literature and community referral information to clients and the community on risk reduction behavior like avoiding needle sharing.
- **Intervention** is cited as the focal point for 11 of the 16 programs. These programs engage individuals who are actively experiencing negative consequences due to substance use. New Jersey Recovery Corps (NJRC) and Police Assisted Addiction and Recovery Initiative (PAARI) are examples of programs that provide intervention services directly after a non-fatal overdose. PAARI aims to engage individuals within 12 to 24 hours after such an incident. In addition, PAARI allows individuals to have a same-day connection to SUD services upon presenting themselves to law enforcement and requesting help.
- **Long-term recovery** provides ongoing services to individuals who have ceased substance use. Three of the sixteen programs provide ongoing or long-term support and case management starting in the intervention phase and typically continuing for six to twelve months. However, Minnesota Recovery Corps (MNRC) sets a unique standard for when services change from intervention to long-term support. The program requires, at minimum, 90 days of sobriety before an individual can access recovery support services.

Duration of intervention

Although each grantee program varies in duration for which an individual can receive services, all but three of the programs state they will provide maintenance or on-going services, i.e. continued service provisions after an individual has successfully engaged in treatment and is living in recovery from their substance use disorder. These programs commit to either periodic check-ins with individuals served or routine, sometimes weekly coaching which can last for over a year. This sustained or re-occurring support builds a trusting relationship between the individual served and their recovery coach.

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[22] Link to training resources: https://www.cdc.gov/dhdsp/programs/spha/chw_training/index.htm.

[23] Link to training resources: https://namivirginia.org/mental-health-resources/peer-support-specialist-information/.

[24] Link to training resources: https://mcshin.org/education/recovery-coach-training/.

Two programs provide a hybrid of services either due to multiple service sites with varying client population or multiple individuals providing service. For example, PAARI provides acute intervention by law enforcement and/or AmeriCorps members when an individual comes to them seeking treatment or after an overdose. At this stage, the individual is screened for risk level and linked to treatment. The individual's support needs may go beyond the duration of an AmeriCorps member's service term. As a result, individuals may be referred to volunteers called "Angels" who will continue to provide informal support to those in recovery after they are connected to treatment.

Individualized plans

In programs providing on-going support throughout an individual's recovery journey, a fundamental aspect is the provision of client-driven service. As previously mentioned, several recovery coach programs utilize motivational interviewing as well as another tool: the self-sufficiency matrix. The self-sufficiency matrix[25] is a measurement tool that can be molded to individual program needs by adding or eliminating any of the 18-25 (depending on version) individual scales. The tool tracks individuals on a continuum from "in-crisis" to "thriving" on scales including childcare, housing, income and mental health. Both tools draw out the strengths and needs of an individual, so recovery coaches can create a recovery or treatment plan around the most pressing needs. Commonly identified needs range from primary medical care to stable housing to employment skills. CNCS grantees also build recovery plans and measures of success around "recovery capital" as detailed in **Figure 1**:

Recovery capital is comprised of three categories of resources which can help or hinder an individual's recovery[26]:

1. Family/Social
2. Personal
3. Community/ Cultural Capital

Figure 1: Recovery Capital Categories

Social capital	Personal capital	Cultural capital
Family support	General health	Beliefs
Significant other	Mental wellbeing	Spirituality
Social support	Nutrition	Sense of purpose
Social mobility	Employment	Cultural relevance
Healthy lifestyle	Education	Sense of community
Access to healthcare	Financial wellbeing	Values
Safety	Housing situation	
	Transportation	
	Clothing	

Connection to community resources

Recovery coaches use the framework of recovery capital and other "whole-person" strategies to address factors beyond substance use that impact one's ability to be successful in recovery. For example, many grantee programs build a ladder of success by connecting individuals with other community resources aside from SUD treatment. Programs go beyond providing an individual with the website for a therapist or job postings and instead go the extra mile to ensure an individual is successfully connected to resources. For example, Maine RecoveryCorps (MERC) recovery coaches will bring job applications to individuals where the individual receives service as those in the correctional system have little access to outside resources. Maggie's Place II (MP2) also personally facilitates service connections by accompanying women to court, eliminating transportation barriers and providing advocacy.

[25] Link to Self-Sufficiency matrix: http://www.performwell.org/index.php?option=com_mtree&task=att_download&link_id=48&cf_id=24.

[26] White, W. & Cloud, W. (2008). Recovery capital: A primer for addictions professionals. Counselor, 9(5), 22-27.

AmeriCorps Recovery Coaching in a Socio-Ecological Model

Those seeking to address SUD and the opioid epidemic through recovery coaching are focused on all aspects of the recoveree's life as well as the people and systems by which the recoveree is impacted. This makes a socio-ecological model (SEM) a great framework to assess these 16 programs with. SEM is a framework used in the social sciences to depict how one issue can be addressed through different connections to the person seeking help. SAMHSA has used the SEM to display factors that influence an individual's risk level for substance use disorder. Below is a description of each level in the model and an example of just one grantee that focuses on that level in their recovery coach program.

The four levels of SEM used are:

1) Individual: Comprised of personal attributes that may impact an individual's risk for substance use or abuse such as age, gender, education level, attitudes and beliefs.

- Grantee example: Mercy Health (MH) works one-on-one with patients in the emergency department to enhance their knowledge of how opioids and heroin affect the body and brain, how it increases the risk for other medical conditions and the negative impact of substance use on relationships and employment. In addition, patients receive assistance eliminating barriers to treatment such as insurance and transportation.

2) Relationship: This level includes a person's closest relationships such as family or spouses. The experiences in these relationships, past or present, may support a person's recovery or draw them into substance use.

- Grantee example: Half of New York Peer Corps' (NYPC) focus is on youth age 14-24 and their families. Recovery coaches provide weekly community meetings and small group support sessions for youth and their families to educate everyone on treatment options and the life-long journey of sustained recovery.

3) Community: Encompasses settings where social connections occur such as school, work and neighborhoods. If supportive, this can be a form of recovery capital where an individual may build links to a sober lifestyle.

- Grantee example: As part of Minnesota Recovery Corps' (MNRC) treatment model, individuals in recovery must identify community service projects and work as a small group to carry out this community service. The intent is to build connections within their community, give back, gain transferable job skills and engage in sober social activities.

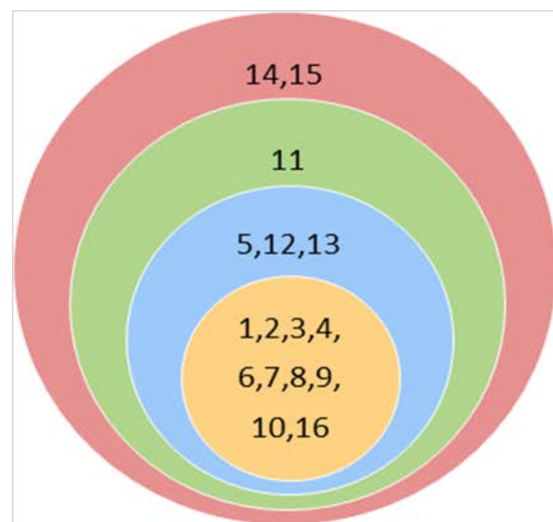
4) Societal: The broadest level in the model includes social and cultural norms and behaviors of the world around us. This includes healthcare policies or societal attitudes towards those who experience substance use disorder.

- Grantee Example: Police Assisted Addiction and Recovery Initiative (PAARI) attempts to change community attitudes about law enforcement by choosing not to punish individuals who acknowledge substance use but rather support them in finding treatment. PAARI wants to make law enforcement a positive, trustworthy resource for support within the community which is typically not the perceived norm.

Figure 2A displays a SEM diagram and Figure 2B plots each of the 16 AmeriCorps projects on a SEM to demonstrate to what extent the program impacts or is dependent on other elements of an individual's environment. As recovery coaching is intended to provide 1-on-1 support, it is not surprising to find that most of the projects only engage with an individual. However, there are several programs that engage family or friends and others that intend to develop supportive community connections or shift cultural norms around SUD and recovery. Projects can operate on more than one level of the SEM diagram, but they are plotted according to their primary connection to the recipient of service.

Figure 2A – SEM Diagram

Figure 2B – AmeriCorps Projects Plotted



Key to Figure 2B – AmeriCorps Projects

1. Alabama Dept. of Mental Health HOOP AmeriCorps, **2.** CARITAS AmeriCorps,
3. Combatting the Opioid Epidemic - Formula Submission, **4.** Detroit Recovery Project,
5. Harbor Homes, Inc., **6.** Maggie's Place II, **7.** Maine RecoveryCorps,
8. Marshfield Clinic AmeriCorps – Recovery Corps, **9.** Mary Hitchcock Memorial Hospital,
10. Mercy Health, **11.** Minnesota Recovery Corps, **12.** New Jersey RecoveryCorps,
13. New York Peer Corps, **14.** Police Assisted Addiction and Recovery Initiative (PAARI),
15. Richmond Area Healthy Futures, **16.** Rio Arriba County II

Measurement of Progress and Results

AmeriCorps programs choose which outputs and outcomes they measure depending on their identified need and intervention strategy. As a result, the measurement of progress and the tools used to track success varied in almost each of the 16 programs.[27] However, three common themes emerged regarding expected outcomes. Individuals receiving recovery coaching services will:

1) report an increase in recovery capital.
2) attend more physical and behavioral health services.
3) experience a decrease in substance use.

Programs anticipating an increase in recovery capital include MNRC, MP2, MERC, and WIRC. Each program uses a holistic lens, setting goals unique to each client related to their physical health, employment status, housing stability and more. These programs also use similar tools to track this outcome. For the second commonly measured outcome, three programs (HOOP, HHI, and MHMH) all anticipate increased use of both recovery services as well as physical health services. However, this expected outcome defines service engagement differently from program to program. Where one

[27] Subsequent to the timeframe of this study, CNCS revised their National Performance Measure options in 2019 to create more standard outcome measures for Recovery Coach programs to utilize

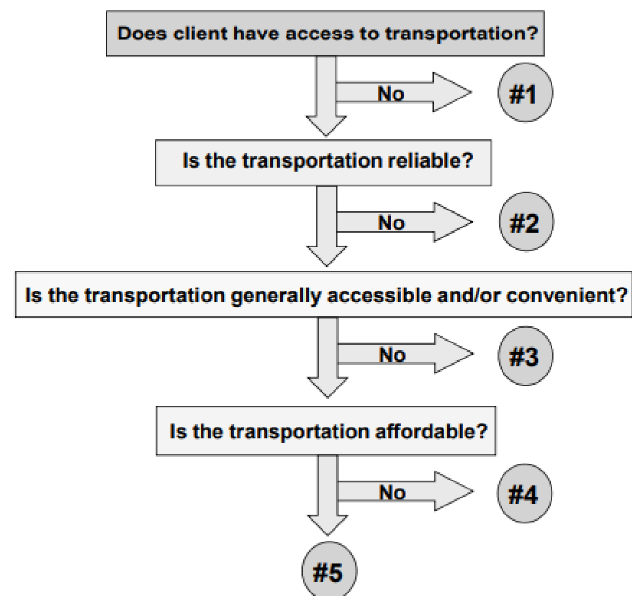
program anticipates that individuals will attend at least one service per week after receiving a referral, another program measures the increase in service engagement as one new visit in a six-month period. Finally, HOOP, MERC, and MH aim to decrease reported substance use because of AmeriCorps recovery coach services. Again, the measurement of duration or extent of an individual's sobriety varies in each program with one anticipating decreased use within 6 months and another striving for individuals with 30 days of uninterrupted sobriety. **Table 5** on the next page lists what each program intends to measure as its outcomes, per their grant applications.

The most common tools used by programs to measure output and outcomes included:

1) Self-reported progress via survey
2) Intake forms
3) Attendance logs.

For programs tracking holistic improvements in recovery capital, programs use two established tools: the recovery capital index and the self-sufficiency matrix (see example in **Figure 3).** Both tools are completed based on client self-assessment with the support of a recovery coach. Clients rate themselves on a 1 to 5 or a 1 to 25 scale regarding their strengths, supports and resources in domains including personal relationships, employment skills, spirituality, mental health, etc. These tools are completed by the recovery coach in conversation with the individual. The recovery coach utilizes these assessments throughout the course of service provision to track areas of growth or improvement. Similarly, other programs create individualized recovery plans with those seeking recovery coaching services. These plans establish short and long-term goals, again on holistic dimensions.

Figure 3: Self-Sufficiency Matrix Scoring Example



In addition, programs utilize other tangentially related systems or tools to track their outcomes. For programs seeking an increase in recovery service usage, these programs track attendance via insurance coverage databases or individual's electronic health records. The Homeless Management Information System (HMIS), created by U.S. Department of Housing and Urban Development, is utilized by two programs. HMIS is utilized by HHI to track the number of individuals in need of recovery support services as the system can track individuals and monitor their housing or health insurance status. CARITAS also utilizes this system to verify whether housing is obtained (expected outcome) for the individuals they provide housing support services.

Table 5: Measures of Project Outcomes on Service Recipients	
Name of Project	**Outcomes**
Alabama Dept of Mental Health HOOP AmeriCorps (HOOP)	1) An improvement in health behaviors for the client 2) A demonstrated reduction in 30-day usage of opioids
CARITAS AmeriCorps (CARITAS)	1) Obtaining employment within 12 months, 2) Obtaining safe, healthy and affordable housing
Combatting the Opioid Epidemic - Formula Submission (COEF)	Self-reported health improvements or positive behavior changes
Detroit Recovery Project (DRP)	TBD
Harbor Homes, Inc. (HHI)	1) Positive outcomes for clients maintaining twelve weeks of recovery, 2) Engagement in recovery services
Maggie's Place II (MP2)	Increased scores on the Arizona Self-Sufficiency Matrix
Maine RecoveryCorps (MERC)	1) Improved community-based recovery capital, 2) At least 30 days of uninterrupted recovery
Marshfield Clinic AmeriCorps - Recovery Corps (WIRC)	Client progress toward one Recovery Service Plan goal
Mary Hitchcock Memorial Hospital (MHMH)	Increased use of primary and behavioral healthcare
Mercy Health (MH)	Decreased substance use
Minnesota Recovery Corps (MNRC)	Increase in recovery capital
New Jersey Recovery Corps (NJRC)	Movement through the Stages of Change
New York Peer Corps (NYPC)	1) Increased understanding of treatments to reverse opioid overdose and manage withdrawal/cravings 2) Building connections to community resources
Police Assisted Addiction and Recovery Initiative (PAARI)	Increase the number of unique individuals with substance use disorder receiving a referral to treatment
Richmond Area Healthy Futures Project (RHF)	1) Improvement in the individualized recovery action plan for each client, 2) An increase in knowledge of risk factors with opioid/Rx drug use
Rio Arriba County II (RAC2)	TBD

In addition to measuring positive outcomes for individuals receiving substance use recovery services, multiple programs articulated the potential impacts of their interventions for AmeriCorps members themselves. For example, RAC2 seeks to increase the number of recovery service and healthcare providers in their community as a result of AmeriCorps members receiving training and experience in these professions. RAC2 also aims to provide meaningful service, as AmeriCorps members, for those in recovery for SUD.

At the time of this write up, progress reports are available for nine of the sixteen recovery coach programs. The most recent progress reports share limited narrative information, but several programs reported the extent to which they met or did not meet their target number for outputs and outcomes. For five of the nine programs that had progress reports available, at least one of their outcome or output goals was met or exceeded. Three of these five programs were measuring an outcome of progress towards a recovery capital goal. An analysis of a larger sample of programs and progress reports could reveal whether recovery coaching is a positive indicator for an increase in recovery capital. Results were less consistent for programs meeting their target goals when measuring other items such as increased knowledge on the risks of opioid misuse, since some programs greatly exceeded their target while others met somewhere between seven and fifty percent of their target outcome. In addition, of the two programs reporting and tracking increased connection or use of primary, behavioral and recovery services as an outcome, the results in meeting their target were inconsistent as one program was very successful (108% of target outcome was met) and another was not (11% of target outcome was met). Out of the nine progress reports reviewed for this study, four of the programs had a progress report but did not provide data on what percentage of their targets were met. Reasons why data were not provided in these cases include ongoing program activities; progress report guidance that does not require formula subgrantees to report specific values for applicant-determined performance measures; and planning grants that do not yet have outcome metrics developed

Grantee progress reports also shed light on recruitment and retention for each program. Although recruitment is addressed later in this document, the measures of retention are worth noting here. For those with an available progress report, retention rates are excellent. Three of the six programs which had submitted progress reports by the time of this writing had a 100% retention rate. It is not clear what factors contributed to this high retention rate. However, this is a topic worth further exploration.

Interview Findings

Staff from five programs were interviewed about their experiences administering recovery coaching programs. Members were additionally interviewed about their roles and the effect service has had on their lives. Trends and findings across different aspects of recovery coaching are highlighted below.

Recruitment

Most programs noted how their recruitment of members is largely offline and through connections made across tightknit recovery networks. Marketing is traditionally grassroots and through the word of mouth, although some programs feature online application processes and formalized Human Resources (HR) practices.

Insofar as members possessing lived experience, programs generally requested prospective members possess a year to two years of lived SUD experience. Programs varied in how they treated indirect lived experience such as if a member's family member suffered from a SUD, and one program even mentioned that other forms of trauma were acceptable so long as the member had displayed perseverance. An example given was that of recovering from an eating disorder. That program stressed the importance of tenacity:

> *"We want somebody that lived life on the harder side of life and understands what it is like to struggle […] at the same time we need them to have grit and overcome things. Just being a recovery coach is hard […] I'm looking for someone who can practice gratitude."*

The presence of lived experience, direct or indirect, was overwhelmingly valued in recruiting potential AmeriCorps members.

Lived Experiences – Successes and Challenges

Relationship Building over Shared Experience

The relationships necessary for successful peer coaching are easily facilitated when the recovery coach has lived experience. Speaking to their own SUD experience, members appear as credible and honest in the options and care they provide as compared to a clinician or other medical professional. None of the interviewed members felt they exclusively served their "peers" since their ages and backgrounds did not necessarily align with who they served, but all members felt their shared lived experience was what mattered most in relationship building with clients. One member said:

> *"Recovery works its crazy way into every age demographic […] One of the greatest things about recovery is you have that foundation and nothing else really matters because you have that connection. When you find the right group of people you learn all different pathways and you accept people as they are."*

Of the interviewed members with direct lived experience, all said their AmeriCorps service has been integral to their own recoveries and noted how they sought out their AmeriCorps position because of their past with SUDs. Whereas traditional avenues into the recovery industry or opportunities to give back may have been closed off because of their experiences, members found that AmeriCorps programs not only permitted lived experience, but openly requested it as a basis for selection.

Time Commitments and Inflexible Schedules

Some programs noted how their members can serve on a part time schedule. One program specifically spoke to the fact that many of their members are still connected to social services and need to meet with their case managers and attend a variety of appointments. Previously operating under a full-time schedule, members in this program were often forced to choose between tending to their own wellbeing or serving. A staff member said:

> *"The demands of a* [full-time] *service week resulted in far more absenteeism for folks to remain connected to those supports. Members could really speak to instances where their housing case management would insist on an appointment and provide a heads up about the appointment the night before without considering that a member has made a commitment to the program."*

To ensure members could properly take care of themselves first and foremost, this program instituted a part time schedule to give members personal days for appointments, therein reducing absenteeism and incomplete service terms. That program is therefore looking to recruit more members to fill in gaps in service a part-time schedule could potentially create.

Retention Issues

Issues with member retention can arise as a result of members' lived experience. All programs utilizing these members mentioned that the chance of member relapse is always present throughout their term of service, and that they have felt pressured to keep members enrolled for the sake of maintaining their retention numbers. They felt that the traditional AmeriCorps retention metrics were not as applicable to programs like theirs because of the chance of member relapse. Keeping members enrolled that were not far enough along in their own recovery had the potential to be a detriment to members themselves as well as the administration of the program overall. One program said:

> *"We can't always keep our patients safe and honor our enrollment and retention requirements at the same time […] We want to do right by AmeriCorps and honor our grant commitment but then we'd end up with people who we know would be trouble from the beginning."*

Navigating Life as a Member and Recoveree

A program mentioned that serving in an AmeriCorps program is the first time many members are entering the workforce which can result in many growing pains. Sometimes members would inadvertently have their member stipends counted as income which would negate some of their income-contingent benefits. Programs noted that some members struggle with living on the AmeriCorps member stipend and have sought out formal recovery coach positions outside of national service because of the pay. They also mentioned that background checks have been difficult to pass for aspiring members because often those with lived experience will also have a criminal record.[28] A program mentioned this challenge in relation to organizations with which the program partners:

> *"A lot of times people who are in recovery from substance use disorder do have a criminal background, so navigating that as it relates to serving in the program, and being thoughtful to our partner organizations some of which are treatment centers that have stricter background requirements than the program overall necessarily would…"*

Value Add of AmeriCorps to Both Program and Member

Capacity Building

Across the board, program staff mention how AmeriCorps members build capacity for organizations that would otherwise not have the resources to deploy crucial recovery coaching services. To administer recovery coaching or a similar intervention through traditional settings could prove to be incredibly costly, whereas AmeriCorps circumvents this barrier. One program responded:

> *"When we're thinking back to recovery coaching models built over the years, they do tend to be more private in nature and can be cost prohibitive. A big value add for Recovery Corps is that is not something that people will necessarily need to pay out of pocket for."*

Any organization treating those with SUDs stands to benefit from the extra capacity AmeriCorps members can build. With the additional capacity, recovery coaches can spend a greater amount of time and energy on each patient as compared to an understaffed clinic:

> *"AmeriCorps members typically bring a fresh and youthful energy to this issue. We also can provide a little more time with these patients compared to a provider or a nurse. A lot of times they have a high volume of patients so they can spend only so much time with them [..] We can practice a compassionate role and sit and talk to the patients rather than just going in and handing them a piece of paper."*

To this extent, AmeriCorps members with lived experience may also be able to provide more effective service than an otherwise "good" SUD treatment intervention. In other words, members' experience and ability to connect with individuals struggling with SUDs is invaluable.

[28] By law, AmeriCorps is required to screen only for murder and sex offenses, but some individual programs opt to institute stricter criminal background requirements.

AmeriCorps Develops Professional Skills
One program mentioned how AmeriCorps provides an extra layer of legitimacy and guidance for its members, many of whom are entering the workplace for the first time. By utilizing existing AmeriCorps structure and guidelines, the program can quickly get its members up to speed on what they can and cannot do in the workplace:

> *"AmeriCorps provides us that structure that we wouldn't have unless we started our own program. If we started our own program, we would need a lot more […] It's a lot of the compliance piece. Our members have to follow under the AmeriCorps umbrella – It helps with the keeping on our end – It provides guidance to our members on things they should and should not do at their host sites. It's not just us – it's additional security."*

Recovery coaching positions tend to include some degree of clerical work which can provide coaches opportunities to develop their administrative skills as well. Looking towards their future after completing their terms, members report leveraging their service when seeking employment or furthering their education. One member said:

> *"Peer Corps has opened many doors and given me many opportunities – I was recently offered two full time job positions, but I had to turn that down because I also received a four-year scholarship. Peer Corps gives plenty of opportunity. Not only do I pay it forward because of my lived experience and because I want to help the community, it also gives me many opportunities in professional development."*

AmeriCorps Helps Members' Own Recovery
Both program staff and members mentioned how those recovering from SUDs stand to benefit from service. As previously mentioned, many opportunities are often closed off for those with lived experience, but members are grateful for the second chances they now have, and dearly want to give back. They are passionate about helping others struggling with SUDs, and AmeriCorps matches that passion and desire to give back with actionable service. A member said:

> *"The greatest thing about being a service member was for my own recovery. It's given me so much that I could not have received anywhere else. I honestly believe I am 500 times stronger in my own recovery than had I not done this program. It's given me tools to work with others, a pipeline in the industry of recovery, passion and excitement, purpose, so many different things."*

All interviewed members felt their life trajectories dramatically improved in ways that would have otherwise been impossible had they not served. One program mentioned that since its members only serve for twelve months, they often feel like they have tangible, manageable goals to work towards instead of immediately jumping into longer term sobriety. Specifically, they noted how coaches will often speak of their commitment to the program that has the potential to prevent relapses:

> *"The coaches tell me they are dedicated to the program. Sometimes they think about using but they don't want to embarrass the program and that stops them from using."*

Programmatic Challenges

Since recovery coaching is mentally demanding, many members expressed their need for regular supervision and check-ins; members serving in isolated, rural areas have reported feeling lonely and depressed. Despite feeling drained from their service, members felt they were provided opportunities to come together as a cohort to work through challenges. One member talked about their techniques for maintaining strong mental hygiene:

> *"[I am] learning to compartmentalize what patients are telling me because it can be just devastating and heavy stuff; finding ways to decompress after a long shift such as self-care activities […] but also connecting with my other corps members helps because they are able to give me insights on what we could do for a certain challenge a person is facing or maybe a couple people are facing the same challenge. To find a group solution, to find what we are all challenged with…"*

The importance of self-care and member readiness could not be overstated. All members noted the challenges to their own mental wellbeing while serving in this role, and it is only exacerbated for those with lived SUD experience.

Some programs experience difficulties in maintaining contact with service recipients once the initial intervention has been administered. This proves to be challenging for measuring program outcomes since many times patients do not have stable addresses and sometimes give false identifying information.

Preliminary Recommendations

A number of preliminary programmatic and measurement recommendations have flowed out of this study. They are as follows:

Programmatic Recommendations

- Consider taking advantage of the scheduling flexibility AmeriCorps provides by allowing members delivering recovery coaching services to serve part-time to near full-time.
    - Consider letting members have off at least one day off a week, or operating on 80% of a full-time schedule, so members have time to tend to their own recoveries.

- Create frequent opportunities for members to connect with each other as a cohort and utilize intentional strategies for creating a supportive social network.

- Note that recruitment for these positions can prove to be difficult and that traditional program targets may not be as applicable for recovery coaching.
    - It may be difficult for recovery coaching programs to meet established enrollment and retention targets, and it is important for both practitioner and funder to be mindful of such in assessing program performance
    - Alternatively, goals for recruitment and retention targets may need to be revisited or modified to account for the realistic probability that some members may not be able to finish their terms for various reasons.

- Ensure members receive continuous mental health checks and are given opportunities to learn about and practice proper mental hygiene.

- Utilize a strong vetting process for outreach and recruitment efforts to properly address how successful applicants' recovery efforts have been as well as any potential past entanglements with law enforcement.
    - Program staff highlighted that if the members are not far enough along in their own recovery journeys, then they stand to jeopardize the program's efficacy. One program has even structured its interviews to catch potential warning signs that applicants may not be far enough along in their recovery to appropriately serve in these roles. Ideally, a member should have one to two years of sustained recovery under their belt prior to starting their service term.

- Ensure that there is alignment between the organization's mission and the intervention model, including leadership buy-in and support for the program for it to be successful.
    - The cohesion of a unified organization tackling SUD from the same stance can prove to be an integral part of a highly-functioning recovery coaching program.

- Consider the best setting for the model to be implemented according to the context in which the program operates. AmeriCorps grantees should not limit themselves to a specific setting when designing their programs since many programs have shown to be successful in a variety of settings based on the context in which they operate.

- Design and implement a tight and proactive monitoring and oversight plan to ensure that both members and clients are on track and the program is operating well and making meaningful progress towards achieving its intended objectives and goals.

Outcome Measurement, Evaluation, and Other Recommendations

There are several recommendations that can assist grantees and advance measurement and evaluation for these program models. By providing greater support to grantees in the planning and implementation phases, they will be empowered in delivering these interventions. Additionally, such support can lay the foundation for advancing measurement support and evaluation of the effectiveness of these program models.

- Develop and support a community of practice for grantees implementing recovery coach models, in order to facilitate sharing of knowledge and best practices across grantees and create a foundation for advancing outcomes measurement and evaluation. Such a community of practice may be online and through teleconferencing or in-person convenings. Support recommendations may include but are not limited to:
    - Webinars/in-person grantee convenings led by experienced grantees to facilitate sharing of knowledge and best practices across grantees
    - Topic for training at the annual AmeriCorps Symposium
    - Technical assistance calls for gathering and evaluating data
    - Recommended consistent outcome measures

- Conduct a “bundled” process and outcomes evaluation of recovery coach program model as a starting point to develop the base of evidence for these programs. The Office of Research and Evaluation at CNCS already is planning to embark on such an evaluation in the coming year. The outcomes evaluation portion of the study can focus on results for members, host organizations, and community members receiving services through the program.

- Consider an impact evaluation of these programs in future program years following one or more process and outcome evaluations by using a rigorous quasi-experimental design study that compares community impact of the recovery program models with those Opioid recovery programs that do not use recovery coaches. The latter group of programs would serve as a counterfactual or comparison group and would allow for measuring the effectiveness of this model.

Conclusion

The Opioid epidemic requires a comprehensive and multi-faceted response. It is important that diverse and thoughtful approaches that mobilize communities at multiple levels are implemented to tackle this complex crisis. All such approaches require fostering collaborations and partnerships. One such approach for engaging and mobilizing diverse community actors is through the evidence-based Stakeholder Engagement in quEstion Development and prioritization (SEED) Method. This is a new, collaborative, participatory, and consultative methodology for engaging diverse stakeholders (e.g. patients, caregivers, and advocates and health professionals) in a process of conceptualizing and prioritizing research questions on health-related topics.[29] CNCS is currently sponsoring a research study in Martinsville, Virginia that is testing this research-based collaboration model for identifying an action plan capable of addressing the opioid epidemic in the Martinsville community. There are other ongoing efforts to use the same approach in Minneapolis, Minnesota.

Recovery coaching is one of the approaches that show promise and is still in the early stages of development and testing. Programs utilizing recovery coaching, particularly those that use national service members, could be beneficial on multiple levels. These programs offer benefits to members as they navigate and sustain their own recovery while helping them develop skills and experiences contributing to their professional development and career advancement. They may also offer a promising strategy for those suffering from SUDs, helping them break away from the grips of this devastating disease and putting them on a pathway towards recovery. It is important to further examine these types of program models beyond the 16 case examples included in this study and test the efficacy of these models as one set of potential solutions, among other, to this epidemic.

[29] More information on the SEED Method can be found at: https://societyhealth.vcu.edu/work/the-projects/the-seed-method-for-stakeholder-engagement.html

Appendix A: Program Elements At-A-Glance

Name of Project	Alabama Dept of Mental Health HOOP AmeriCorps (HOOP)	CARITAS AmeriCorps (CARITAS)	Combatting the Opioid Epidemic - Formula Submission (COEF)	Detroit Recovery Project (DRP)	Harbor Homes, Inc. (HHI)	Maggie's Place II (MP2)	Maine RecoveryCorps (MERC)	Marshfield Clinic AmeriCorps - Recovery Corps (WIRC)
State	Alabama	Virginia	New York	Michigan	New Hampshire	Arizona	Maine	Wisconsin
Federal Funding Amount	$276,594	$235,106	$229,689	$110,939	$298,640	$248,426	$283,768	$276,600
Funding Year	2017	2018	2018	2017	2018	2018	2018	2018
Member Service Years	20	17	15.77	0	20	20	20.54	20
Target Population	Veterans who use substances and are at risk for contracting blood-borne diseases	Individuals with substance use disorder in need of housing	Individuals seeking treatment for substance use disorder`	TBD	Individuals in recovery and their families	Women experiencing homelessness and opioid use disorder	Individuals seeking treatment for substance use disorder, specifically Opioid Use Disorder	Individuals seeking treatment for substance use disorder
Grant stage: Planning, Implemented, Withdrawn	Withdrawn	Implemented	Implemented	Planning	Implemented	Implemented	Implemented	Implemented
Setting for Service	Rehabilitation centers, mental health centers, sober house, and recovery centers	Shelters and community resource centers	Recovery centers and health centers	Men's recovery housing, and health and wellness recovery resource centers	Recovery community centers; emergency shelters/centers; residential care facilities; health care centers	Homeless shelters	Law enforcement agencies (sheriff's offices/police departments); mental health centers; recovery centers; community organizations; hospitals	Behavioral health clinics and drug treatment centers
Outcome Measurement	1) An improvement in health behaviors for the client 2) A demonstrated reduction in 30-day usage of opioids	1) Obtaining employment within 12 months, 2) Obtaining safe, healthy and affordable housing	Self-reported health improvements or positive behavior changes	TBD	1) Positive outcomes for clients maintaining 12 weeks of recovery, 2) Engagement in recovery services	Increased scores on the Arizona Self-Sufficiency Matrix	1) Improved community-based recovery capital, 2) At least 30 days of uninterrupted recovery	Client progress toward one Recovery Service Plan goal

Appendix A: Program Elements At-A-Glance, Continued

Name of Project	Mary Hitchcock Memorial Hospital (MHMH)	Mercy Health (MH)	Minnesota Recovery Corps (MNRC)	New Jersey Recovery Corps (NJRC)	New York Peer Corps (NYPC)	Police Assisted Addiction and Recovery Initiative (PAARI)	Richmond Area Healthy Futures Project (RHF)	Rio Arriba County II (RAC2)
State	New Hampshire	Ohio	Minnesota	New Jersey	New York	Massachusetts	Virginia	New Mexico
Federal Funding Amount	$221,279	$149,280	$600,000	$76,335	$294,000	$283,980	$138,186	$30,000
Funding Year	2018	2018	2018	2018	2018	2018	2018	2018
Member Service Years	16	10	30	5.29	20	15	10	0
Target Population	Individuals with substance use disorder or mental health needs	Emergency Department patients at risk for substance use disorder	Individuals seeking treatment for substance use disorder	Individuals seeking treatment for substance use disorder	Youth with substance use disorder and their families, homeless individuals with substance use disorder	Individuals seeking treatment for substance use disorder or those with a recent non-fatal overdose	Individuals seeking treatment for substance use disorder with focus on men and college students	Individuals seeking treatment for substance use disorder
Grant stage: Planning, Implemented, Withdrawn	Implemented	Implemented	Implemented	Implemented	Implemented	Implemented	Implemented	Planning
Setting for Service	Healthcare systems	Emergency Departments	Sober housing, recovery centers, recovery high schools	Recovery centers and emergency rooms	Homeless shelters and Family Resource Centers	Police departments	College campus, community center, jails, hospitals	Clinics, hospitals, community mental health centers, treatment centers, and detention center.
Outcome Measurement	Increased use of primary and behavioral healthcare	Decreased substance use	Increase in recovery capital	Movement through the Stages of Change	1) Increased understanding of treatments to reverse opioid overdose and manage withdrawal/cravings, 2) Building connections to community resources	Increase the number of unique individuals with substance use disorder receiving a referral to treatment	1) Improvement in the individualized recovery action plan for each client, 2) An increase in knowledge of risk factors with opioid/Rx drug use	TBD

Appendix B: One Pagers on Programs Using Recovery Coach Model

1. **Alabama Department of Mental Health**
   AmeriCorps Health Outreach and Opioid Prevention (HOOP)

2. **CARITAS**
   CARITAS AmeriCorps

3. **Center for Family Services**
   RecoveryCorps

4. **City of Richmond – Human Services Commission**
   Richmond Area Healthy Futures Project

5. **Detroit Recovery Project**

6. **Harbor Homes, Inc.**

7. **Healthy Acadia**
   Maine Recovery Corps Program Project

8. **Maggie's Place Project**
   Maggie's Place II

9. **Marshfield Clinic Research Foundation**
   Marshfield Clinic AmeriCorps – Recovery Corps

10. **Mary Hitchcock Memorial Hospital**

11. **Mercy Health**

12. **New York Office of the Mayor**
    Peer Corps

13. **Police Assisted Addiction and Recovery Initiative (PAARI)**

14. **Reading & Math, Inc.**
    Recovery Corps

15. **Rio Arriba County**
    Rio Arriba County II

16. **Rural Health Network of South Central New York**
    Combatting the Opioid Epidemic – Formula Submission

ALABAMA DEPARTMENT OF MENTAL HEALTH AMERICORPS HEALTH OUTREACH AND OPIOID PREVENTION (HOOP)

ALABAMA

ABOUT THE GRANTEE

The Alabama Department of Mental Health (ADMH) provides mental health and intellectual disability services to the people of Alabama. ADMH has three divisions: Administration, Developmental Disabilities, and Mental Illness and Substance Abuse Services. The Office of Substance Abuse Treatment and Development manages the state's publicly funded system of treatment and recovery support services for substance use disorders. ADMH serves as the State Methadone Authority for Alabama's federally approved opioid treatment programs and has established state rules that govern the operations of those programs. ADMH is a 2016 recipient of a five-year Screening, Brief Intervention, and Referral to Treatment grant from the Substance Abuse and Mental Health Services Administration, which brings those practices to rural areas in western Alabama.

FUNDING LEVEL

Total 2017: $409,852

- **Federal 2017:** $276,594
- **Applicant Match:** $133,258

AMERICORPS MEMBERS

Funding Year 2017 20 full-time members, 20 MSYs*

**Member Service Year (MSY): One MSY is equivalent to one full-time AmeriCorps member serving 1,700 hours.*

COMMUNITY PARTNERSHIPS

Cullman Mental Health Center, Mountain Lakes Behavioral Healthcare/Cedar Lodge, West Alabama Mental Health Center, The Salvation Army: Dauphin Way Lodge, Fellowship House, Northwest Alabama Treatment Center, Lighthouse Counseling Center, Inc., St. Clair County Day Program, Inc., The Bridge, Inc., and Tuscaloosa Treatment Center

SETTING

Rehabilitation centers, mental health centers, sober houses, and recovery centers

BACKGROUND

In 2014, the Centers for Disease Control and Prevention (CDC) identified Alabama as the highest painkiller-prescribing state, with doctors writing 143 prescriptions per 1,000 residents. Additionally, CDC has found that sustained opioid use leads to addiction and that many people who become addicted to prescription opioids will later turn to heroin. The AmeriCorps HOOP program has targeted outreach in nine counties with some of the highest rates of addiction and overdose in Alabama.

INTERVENTION OR PROGRAM MODEL

Alabama's AmeriCorps HOOP program members work to address prescription opioid abuse and the use of illicit opioids. Members provide referrals for treatment, testing, and other medical and support services.

ROLE OF MEMBERS

Using strategies from their training, supervised members educate participants with up-to-date, accurate, and appropriate information to support risk-reduction efforts and behavior change. Members advocate on behalf of participants, providing referrals and/or facilitating access to drug treatment and/or testing, counseling and/or support services, and other appropriate medical/social services.

MEASURES

Progress is measured by the Substance Abuse and Mental Health Administration client-level Government Performance and Results Act (GPRA) tool. The GPRA tool collects data measures including numbers, contact details and demographics of those served, dosage and utilization, self-reported substance use history and usage, self-reported behavior change, and health history. Data collection begins at the start of an intervention and ends when sufficient data is collected.

Program measures include:

- Output: Number of clients participating in health education programs
- Outcome: Level of improvement in health behaviors in clients who utilized services.
- Outcome: Demonstrated Reduction in 30-day usage of opioids

The preceding information was gathered from the grantee's application for federal funding. The descriptions provided do not represent the views of the Corporation for National and Community Service, AmeriCorps State and National, or Office of Research and Evaluation. The information provided does not constitute an endorsement of the grantee.

CARITAS
CARITAS AMERICORPS

VIRGINIA

ABOUT THE GRANTEE

Caritas has operated since 1991. Originally formed to provide homeless services as a housing-first initiative in partnership with local churches, Caritas now works with over 150 congregations to provide additional shelter to more than 800 individuals in need. It provides job training and furnishings for recently housed families. Caritas has been an AmeriCorps grantee since 2013.

FUNDING LEVEL

Total 2018: $379,201

- **Federal 2018:** $235,106
- **Applicant Match:** $144,095
  - **Public:** $94,095
  - **Private:** $50,000

Federal 2017: $235,106

AMERICORPS MEMBERS

Funding Year 2018: 3 full-time members, 28 non full-time members, 17 MSYs*

Funding Year 2017: 3 full-time members, 28 non full-time members

**Member Service Year (MSY): One MSY is equivalent to one full-time AmeriCorps member serving 1,700 hours.*

COMMUNITY PARTNERSHIPS

150 local church congregations

SETTING

Homeless shelters and community resource centers

BACKGROUND

A point-in-time study in 2016 found that out of the 688 adults experiencing homelessness in Richmond, 46 percent reported having a problem with substance abuse at some point. In Richmond, very few recovery options exist for adults experiencing homelessness as a result of addiction.

INTERVENTION OR PROGRAM MODEL

AmeriCorps members, along with case managers, connect clients to community resources, affordable and favorable housing, and the support they need to be stable. Participants receive unlimited access to case management throughout the 60-day program. They also participate in a five-week job training program in which they receive integrated instruction on job search skills, leadership, conflict resolution, computer training, practice interviews, and other skills needed to sustain employment.

Economically disadvantaged AmeriCorps members serve 35–40 hours per week for the duration of their half-time contract, gaining experiential learning through service in Caritas' Furniture Bank and the Healing Place as well as the soft skills required to obtain and sustain employment.

ROLE OF MEMBERS

The program recruits members who have graduated from the Healing Place to leverage their lived experience. They assist participants with finding housing, determining immediate needs, providing employment mentoring, and serving in the Caritas Furniture Bank.

MEASURES

Using agency records and the client tracking database, Caritas tracks the number of individuals receiving housing placement services and job training or skill development.

Program measurements include:

- Output: Number of economically disadvantaged individuals receiving job training or other skill development services
- Outcome: Number of participants completing the program that gain employment within 12 months
- Output: Number of economically disadvantaged individuals receiving housing placement services
- Outcome: Number of individuals transitioned into safe, healthy, affordable housing

The preceding information was gathered from the grantee's application for federal funding. The descriptions provided do not represent the views of the Corporation for National and Community Service, AmeriCorps State and National, or Office of Research and Evaluation. The information provided does not constitute an endorsement of the grant

CENTER FOR FAMILY SERVICES RECOVERYCORPS

NEW JERSEY

ABOUT THE GRANTEE

Center for Family Services (CFS) is a non-profit human services agency that began operations in 1920. Its mission is to support and empower individuals, families, and communities to achieve a better life through vision, hope, and strength.

CFS administers 70 programs focused on community outreach, school-based and after-school programs, substance abuse and intensive home-based treatment programs, individual and family counseling, case management, foster care, workforce development, and emergency shelters and residential facilities for at-risk youth.

CFS has been operating AmeriCorps programs since 2010 and currently runs two AmeriCorps programs and an AmeriCorps VISTA program with up to 24 members.

FUNDING LEVEL

Total 2018: $181,335

- **Federal 2018:** $76,335
- **Applicant Match**: $105,000

AMERICORPS MEMBERS

Funding Year 2018: 20 non full-time members, 5.29 MSYs*

**Member Service Year (MSY): One MSY is equivalent to one full-time AmeriCorps member serving 1,700 hours.*

COMMUNITY PARTNERSHIPS

The Center for Research and Evaluation on Education and Human Services at Montclair State University, Cooper University Health Care, Inspira Medical Center, and Jefferson Stratford Hospital

SETTING

Police departments, recovery centers, family service centers

BACKGROUND

Between 2010 and 2015, New Jersey experienced a 214 percent increase in drug overdose rates. Every county in the state reported at least six overdoses in the first three months of 2018. Additionally, southern New Jersey is largely rural and has few resources to address this crisis.

INTERVENTION OR PROGRAM MODEL

AmeriCorps members serve as peer recovery coaches at several sites. Supporting trained clinicians, members provide one-on-one interactions with clients in need of education and referrals. Members move through three tiers of service, gaining responsibility as they acquire knowledge of the program and grantee. The first tier focuses on recovery training, the process of completing intakes, and providing referrals at the Living Proof Recovery Center. In the second tier, members shadow staff at multiple sites and link individuals to recovery services. In the final tier, members can choose the site where they wish to serve as peer-based recovery support specialists, providing one-on-one support to clients. At this stage, members also engage with individuals needing support throughout the community via police ride-alongs and other outreach activities with emergency medical staff.

ROLE OF MEMBERS

Members provide wraparound support to clients by making referrals to opioid recovery community partners and following up on referrals. Ideally, over the course of a member's 450 hours of service, they directly interact with an average of 30 clients participating in health education programs, make 30 referrals and/or linkages to opioid addiction recovery services, and make at least eight follow-up phone calls to program participants to assess progress.

MEASURES

Measures include a rigorous pre-test/post-test design and post-service tracking to assess the intervention's impact, follow-up calls to clients, and referrals and linkages to resources.

The CFS case management system houses all data of clients served by this program. Progress or success in recovery is demonstrated by clients moving through the stages of change. This determination is reached using motivational interviewing conducted by AmeriCorps members.

Program measures include:

- Output: Number of clients participating in health education programs
- Outcome: Number of participants in health education showing movement through Stages of Change/SAMHSA's four dimensions

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CITY OF RICHMOND – HUMAN SERVICES COMMISSION RICHMOND AREA HEALTHY FUTURES PROJECT

VIRGINIA

ABOUT THE GRANTEE

The City of Richmond's Office of Human Services serves as the fiscal agent for grant funding. Richmond has an Administrator of Community Programs staff member with more than 10 years of experience in managing and coordinating programs to include fiscal responsibility and impact reporting.

This program has members serving at multiple sites. The Virginia Commonwealth University (VCU) Rams in Recovery (RIR) site supervisor is a former AmeriCorps member, having served two terms and supervising AmeriCorps VISTA members, and the Caritas location currently operates an AmeriCorps program.

FUNDING LEVEL

Total 2018: $252,400

- **Federal:** $138,186
- **Applicant Match**: $114,214

Federal 2017: $138,186

AMERICORPS MEMBERS

Funding Year 2018: 6 full-time members, 8 non full-time members, 10 MSYs*

Funding Year 2017: 6 full-time members, 8 non full-time members, 10 MSYs*

**Member Service Year (MSY): One MSY is equivalent to one full-time AmeriCorps member serving 1,700 hours.*

COMMUNITY PARTNERSHIPS

Caritas, McShin Foundation, REAL LIFE Community Center, Virginia Commonwealth University, Virginia Recovery Foundation, and Friends of Prevention Coalition

SETTING

College campus, community centers, jails, and hospitals

BACKGROUND

There is an increasing need for direct prevention and intervention services to better respond to Virginia's intensifying opioid crisis centered in Richmond. According to the Virginia Office of the Chief Medical Examiner, Virginia's overdose deaths mostly occur in populous localities in the state's urban crescent, including Richmond and its suburbs. At VCU, one of the service sites for AmeriCorps members, more than 3 percent of first-year students report using non-prescribed opioids or heroin. By their second year, this percentage increases to more than 6 percent. Evidenced by increases in drop-out rates and substance misuse rates, this is an especially vulnerable time in the critical stages between adolescence and early adulthood that determine a young individual's future.

INTERVENTION OR PROGRAM MODEL

The Richmond Area Healthy Futures (RAHF) project intervention is a coalition approach to expand the availability of opioid and heroin prevention and intervention programs within the City of Richmond. Each site's implementation of AmeriCorps members varies. The Virginia Recovery Foundation (VRF) focuses on using law enforcement following an individual's overdose to offer treatment wherein VRF makes arrangements for treatment using peer recovery support interventions. At VCU, the RIR program uses AmeriCorps members as recovery coaches to expand services and support to students. The McShin Foundation uses its AmeriCorps members as recovery coaches to increase its social support groups and one-on-one life skills trainings for participants in the recovery residence program. The Friends of Prevention Coalition (FOPC) works to bring together public and private partners to examine root causes, raise awareness of opioids, articulate community needs, and provide resources to improve community conditions as a way to create a sustainable, drug-free environment. The Caritas recovery program, called the Healing Place, is a male-only program that provides shelter, clothing, food, program supplies, and peer-based recovery services. Caritas teaches men how to achieve long-term sobriety.

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CITY OF RICHMOND – HUMAN SERVICES COMMISSION RICHMOND AREA HEALTHY FUTURES PROJECT

VIRGINIA

ROLE OF AMERICORPS MEMBERS

The VRF AmeriCorps members are trained as peer recovery coaches to better arrange for treatment placements when visiting post-overdose clients. VCU RIR members provide peer recovery support in the recovery clubhouse during day and evening hours, and keep the space open for meetings, fellowship, and studying.

The Caritas program AmeriCorps members at the Healing Place provide peer mentoring to individuals with substance use disorders, train peer mentors, and assist clients transitioning to life in recovery. The program also trains FOPC members to educate and share fundamental information to dissuade individuals from using alcohol, tobacco, and other drugs, and from engaging in other high-risk behaviors while participating in community and group interaction programs.

MEASURES

The program uses pre- and post-assessments of knowledge and attitudes. It also distributes surveys to participants of group interactions and conducts weekly, monthly, and quarterly follow-up checks to monitor recovery success.

The RAHF Recovery Tool was created based on existing Alcoholics Anonymous models for use in this program.

Program measures include:

- Output: Number of clients participating in health education programs.
- Outcome: Number of clients who demonstrate improvement in the individualized recovery action plan.
- Outcome: Number of participants with increased knowledge of risk factors associated with opioid/Rx drug use.

The preceding information was gathered from the grantee's application for federal funding. The descriptions provided do not represent the views of the Corporation for National and Community Service, AmeriCorps State and National, or Office of Research and Evaluation. The information provided does not constitute an endorsement of the grantee

DETROIT RECOVERY PROJECT

MICHIGAN

ABOUT THE GRANTEE

Founded in 2001, the Detroit Recovery Project (DRP) is a community-based organization in Detroit dedicated to addressing the needs of individuals and families challenged with co-occurring substance use and mental health conditions. DRP serves more than 5,000 individuals annually and is licensed by the Michigan Department of Licensing and Regulatory Affairs.

FUNDING LEVEL

Total 2017: $176,930

- **Federal 2017:** $110,939
- **Applicant Match:** $65,991

AMERICORPS MEMBERS

Number of members has not been specified per the planning grant status.

COMMUNITY PARTNERSHIPS

Above and Beyond Child Care Center, New Center Community Health Services, and SHAR (Self-Help Addiction Rehabilitation, Inc.)

SETTING

Recovery housing (for men only) and recovery resource centers

BACKGROUND

In the Detroit area, recovering persons often lack access to life skills training, educational opportunities, and work skills training within supportive or permanent housing programs. Additionally, recovering persons often lack financial support, health insurance, and employment. In a survey of 371 persons in recovery in Detroit, only 23 percent were currently employed; however, almost all were interested in education or vocational training. Of the respondents, one-third were diagnosed with mental health problems, 40 percent had been victims of severe violence, and many had difficulty accessing programs and services to aid them in their recovery.

INTERVENTION OR PROGRAM MODEL

The program model and some other details of this grant are yet to be determined as this was a planning grant and the information does not come from an implemented program. The intent of the program is for AmeriCorps members to address the opioid epidemic in inner-city Detroit by closely working with DRP recovery coaches. Members will help individuals secure housing and employment and focus on health needs that lead to long-term recovery. The goal of the planning grant is to build community networks that support recovery by developing an operations manual, policies, procedures, a training manual, and the necessary systems for member management, site recruitment, evaluation and assessment of member service activities, and the overall building of DRP capacity for a successful AmeriCorps program grant.

ROLE OF MEMBERS

There are four evidence-based practices on which future AmeriCorps members would be trained to understand the dynamics of working with individuals who have substance use disorder and/or mental illness.

Trainings include:

- Motivational Interviewing
- Integrated Dual Disorder Treatment
- Seeking Safety Trauma and Suicide Informed, Recovery-Oriented Systems of Care
- The Illness Management and Recovery Model

MEASURES

Applicant has not identified tools, measures, outcomes or outputs as this is a planning grant.

The preceding information was gathered from the grantee's application for federal funding. The descriptions provided do not represent the views of the Corporation for National and Community Service, AmeriCorps State and National, or Office of Research and Evaluation. The information provided does not constitute an endorsement of the grantee.

HARBOR HOMES, INC.

NEW HAMPSHIRE

ABOUT THE GRANTEE

Harbor Homes, Inc. (HHI) is a private, non-profit organization that has provided support for New Hampshire's most vulnerable citizens since 1982. HHI has connections with local fire stations through the Safe Station initiative. The Safe Station initiative connects individuals seeking recovery services to HHI, which then arranges for transportation, assessment, treatment planning, and, if necessary, emergency housing.

FUNDING LEVEL

Total 2018: $540,360

- **Federal 2018:** $298,640
- **Applicant Match:** $241,720
  - **Public:** $200,000
  - **Private:** $41,720

AMERICORPS MEMBERS

Funding Year 2018: 20 full-time members, 20 MSYs*

**Member Service Year (MSY): One MSY is equivalent to one full-time AmeriCorps member serving 1,700 hours.*

COMMUNITY PARTNERSHIPS

Greater Tilton Area Family Resource Center, Keene Serenity Center, Nashua's Safe Station, Navigating Recovery of the Lakes Region, North Country Serenity Center, Revive Recovery Center, Safe Harbor Recovery Center, SOS Recovery Community Organization, Southern New Hampshire HIV/AIDS Task Force, Welcoming Light, and White Horse Addiction Recovery Center

SETTING

Recovery community centers, emergency shelters/centers, residential care facilities, and health care centers

BACKGROUND

Despite New Hampshire having the second highest death rate from opioids in 2015, resources remain scarce. In 2016, New Hampshire's opioid crisis reached a new peak of 485 deaths, a 250 percent increase in overdoses in only four years. The state has the least substance misuse treatment programs per capita in New England and even fewer programs directed toward low-income populations. In the state's second-largest city, Nashua (the primary focus of this application's proposed interventions), a non-profit residential facility has wait times of at least two weeks for adults. For at-risk populations, such as expectant mothers and their children, wait times can exceed one month.

INTERVENTION OR PROGRAM MODEL

Recovery Corps members offer recovery coaching services to clients, building positive relationships and encouraging them to pursue their next step in recovery. Members also provide appointment reminders and case management with the goal of increasing clients' recovery capital (recovery support services). AmeriCorps members serve in three cohorts mirroring three of the four service areas recommended by New Hampshire's Recovery and Resiliency-Oriented System of Care: pre-treatment and intervention, treatment and recovery, and post- and extra-recovery supports.

ROLE OF MEMBERS

Members' caseloads vary depending on their cohort, host site, intensity of services, and complexity of cases. On average, members serve approximately six clients/week (six hours per client), building relationships and providing support as needed. The goal of members' service is to build clients' recovery capital through identifying resources to remove barriers to care, increasing resiliency, and encouraging clients to pursue and maintain recovery.

MEASURES

Electronic health records or case management databases are used to track clients. To assess outcomes, members survey clients on whether they have experienced positive outcomes including living in safe housing, meaningful reduction in drug use or alcohol, increased job skills and/or education/employment opportunities, and reduced family conflict.

Program measures include:

- Output: Number of uninsured, economically disadvantaged individuals using health care services/program
- Outcome: Percentage of clients maintaining 12 weeks of recovery who report two or more positive outcomes
- Outcome: Percentage of served individuals who enter into recovery and use at least one recovery service

The preceding information was gathered from the grantee's application for federal funding. The descriptions provided do not represent the views of the Corporation for National and Community Service, AmeriCorps State and National, or Office of Research and Evaluation. The information provided does not constitute an endorsement of the grantee.

HEALTHY ACADIA MAINE RECOVERY CORPS PROGRAM PROJECT

MAINE

ABOUT THE GRANTEE

Healthy Acadia is a 501(c)(3) non-profit organization dedicated to empowering people and organizations to build healthy communities and helping people lead healthy lives. Healthy Acadia is aware of how to carry out recovery coach programs as multiple staff were trained in 2016 in the Connecticut Community for Addiction Recovery method. They have since trained more than 100 recovery coaches. They also piloted recovery coaching services in Hancock and Washington counties, in the jail systems, and within communities. In the last decade, Healthy Acadia has hosted 15 AmeriCorps members.

FUNDING LEVEL

Total 2018: $649,607

- **Federal 2018:** $283,768
- **Applicant Match:** $365,839
  - **Public:** $141,000
  - **Private:** $224,839

AMERICORPS MEMBERS

Funding Year 2018: 18 full-time members, 12 non full-time members, 20.54 MSYs*

*Member Service Year (MSY): One MSY is equivalent to one full-time AmeriCorps member serving 1,700 hours.

COMMUNITY PARTNERSHIPS

Law enforcement agencies, health care service providers, harm reduction and recovery service providers

SETTING

Law enforcement agencies (sheriffs' offices/police departments), mental health centers, recovery centers, community organizations, and hospitals

BACKGROUND

Barriers to accessing care and succeeding in recovery include low socioeconomic status, intergenerational substance use, and the rural nature of the region served in northeastern Maine. In 2016, Maine experienced a 38 percent increase in the total number of drug fatalities from 2015, with 84 percent of all drug overdoses in the state caused by at least one opioid. Coastal communities have been especially impacted due to high rates of physical injury and prescribed pain medication among fishermen and lobstermen.

INTERVENTION OR PROGRAM MODEL

Recovery coaching is a form of peer-based support in which recovery coaches honor all paths to recovery and help promote recovery by removing barriers and obstacles. Maine Recovery Corps (MERC) targets individuals struggling with opioid use disorder who are at any stage of recovery. MERC coaches serve as personal guides and mentors for the person seeking recovery (recoveree), helping the recoveree navigate systems to meet his or her needs. Coaches also provide peer-based support services that are recoveree-centered and action-oriented to help recoverees meet their treatment, wellness, and recovery support goals. Recovery coaching continues for as long as recoverees need it, even if that time period exceeds an AmeriCorps member's service year (the recoveree would be transitioned to a new recovery coach).

ROLE OF MEMBERS

Recovery coaching occurs on a regular basis, based on the schedule and needs of the recoveree. A Recovery Corps member recovery coach meets with the recoveree on a weekly basis between 30 and 60 minutes where the member is hosted, such as a jail, a health care setting, or the office of a participating community organization. The recoveree's needs and interests guide the meetings, with a focus on addressing any concerns or challenges that the recoveree is facing, as well as implementing the recoveree's action plan.

HEALTHY ACADIA
MAINE RECOVERY CORPS PROGRAM PROJECT

MAINE

MEASURES

Outputs are recorded on a spreadsheet tracking form and reviewed by a program director. The self-sufficiency matrix serves as the instrument for tracking outcomes. This matrix consists of a client-reported assessment of a variety of outcomes including access to services, health insurance, housing, basic needs, transportation, and physical health. Clients will follow this self-assessment exercise at set intervals following support sessions.

Program measures include:

- Output: Number of individuals engaging in recovery coaching services
- Outcome: Number of individuals experiencing improved community-based recovery capita
- Outcome: Number of individuals experiencing at least 30 days of uninterrupted recovery

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MAGGIE'S PLACE PROJECT MAGGIE'S PLACE II

ARIZONA

ABOUT THE GRANTEE

Maggie's Place operates five homeless shelters and a Family Success Center designed as a one-stop shop for an array of resources, including food, legal, and employment assistance and parenting education and activities. Maggie's Place programs target homeless women and their children experiencing trauma and addiction. All clients meet homeless guidelines for poverty, and 61 percent report opioid addiction.

FUNDING LEVEL

Total 2018: $414,488

- **Federal 2018:** $248,426
- **Applicant Match:** $166,062 (private funding)

AMERICORPS MEMBERS

Funding Year 2018: 20 full-time members, 20 MSYs*

**Member Service Year (MSY): One MSY is equivalent to one full-time AmeriCorps member serving 1,700 hours.*

COMMUNITY PARTNERSHIPS

ASU Morrison Institute

SETTING

Homeless shelters and community resource center

BACKGROUND

Maricopa County, Arizona, represents 61 percent of the state's population and 54 percent of the state's homeless population. In addition, more than 39 percent of all individuals in Maricopa County experiencing homelessness self-report some level of mental or physical disability or substance abuse.

Of the clients residing in Maggie's Place shelters, 61 percent report an opioid addiction. As such, Maggie's Place aims to expand intervention strategies to include new one-on-one mentoring for every client, thus strengthening resources in substance abuse reduction and prevention of opioid use.

INTERVENTION OR PROGRAM MODEL

Maggie's Place provides integrated, locally based services that are family-focused and culturally sensitive. It also provides social services information, helps get referrals, and assists families with setting goals, learning skills, and accessing resources. Members serving as recovery coaches are a critical component of the team effort in helping those with substance abuse disorders develop recovery capital. Recovery coaches provide one-on-one coaching on risk factors common to addiction during the first program year. Maggie's Place recovery coaches use the Arizona Self-Sufficiency Matrix to guide clients' recovery. The Arizona Self-Sufficiency Matrix is a tool used to measure recovery capital, including support networks, employment level, and motivation (among other things).

ROLE OF MEMBERS

Over the course of 12 weeks, members spend six hours per week with each assigned client, working on core capabilities to enhance a client's ability to focus, plan, and achieve goals, adapt to changing situations, and resist impulsive behavior. Members also collaborate with project-specific trained volunteers.

During the year of service, a mobility mentor works with 19 to 23 clients during any given week at an assigned shelter or the Family Mobility Center. The member is part of the eight-member house team that meets weekly to assess each client's progress. Two of the team members are the AmeriCorps supervisor and the house case manager, who also oversee the member onsite at the assigned location. After conducting an initial two-hour intake meeting, future meetings focus on working through the program curriculum with each client and serving as a resource broker (e.g., going to court as an advocate on behalf of the client, driving the client to key appointments, supporting job readiness, securing health insurance, building parenting skills).

MAGGIE'S PLACE PROJECT
MAGGIE'S PLACE II

ARIZONA

MEASURES

Quantitative and qualitative data collection points for the evaluation draw from (1) initial intake forms, (2) the Arizona Self-Sufficiency Matrix, (3) client surveys, (4) focus groups, and (5) client participation logs. The matrix design is flexible, as any combination of 25 scales can apply depending on the goals and strategies.

The matrix serves as the instrument for tracking outcomes. This matrix consists of a client-reported assessment of a variety of outcomes including access to services, health insurance, housing, basic needs, transportation, and physical health. Clients follow this self-assessment exercise at set intervals after support sessions.

Program measures include:

- Outputs: Number of women receiving mentoring services
- Outcomes: Number of women with increased scores on the Arizona Self-Sufficiency Matrix

The preceding information was gathered from the grantee's application for federal funding. The descriptions provided do not represent the views of the Corporation for National and Community Service, AmeriCorps State and National, or Office of Research and Evaluation. The information provided does not constitute an endorsement of the grantee.

MARSHFIELD CLINIC RESEARCH FOUNDATION – MARSHFIELD CLINIC AMERICORPS – RECOVERY CORPS

WISCONSIN

ABOUT THE GRANTEE

The Marshfield Clinic Center for Community Outreach (CCO) was established in 1998 to address population-based prevention strategies. Since 2000, CCO has received 26 AmeriCorps awards for four different programs and has managed and operated a tribal AmeriCorps program through a contractual agreement with Wisconsin's tribal nations. In 2014, the Wisconsin state legislature passed the Heroin and Opiate Prevention and Education (HOPE) legislative package including funding to establish opioid treatment programs in three underserved regions. Formed in May 2015, the HOPE Consortium provides referrals for individuals in need of recovery coaching through CCO. It is a partnership between 12 substance use disorder treatment organizations serving Forest, Iron, Oneida, Price, and Vilas counties as well as three federally recognized tribes, including Forest County Potawatomi, Lac du Flambeau Band of Lake Superior Chippewa, and the Sokaogon Chippewa Community.

FUNDING LEVEL

Total 2018: $406,263

- **Federal 2018:** $276,600
- **Applicant Match**: $129,663
  - **Public:** $90,929 **Private:** $38,734

Federal 2017: $276,600

AMERICORPS MEMBERS

Funding Year 2018: 20 full-time members, 20 MSYs*

Funding Year 2017: 20 full-time members, 20 MSYs*

**Member Service Year (MSY): One MSY is equivalent to one full-time AmeriCorps member serving 1,700 hours.*

COMMUNITY PARTNERSHIPS

Helios Addiction Recovery Services, LLC and HOPE Consortium Partners

SETTING

Behavioral health clinics, drug treatment centers

BACKGROUND

In the served Wisconsin counties, the proportion of narcotic prescriptions (61 to 63 percent), emergency room visits for poisoning (2.4–3.2 per 1,000 people), drug-related hospitalizations (3.0–5.0 per 1,000 people), and opioid-specific hospitalizations for those aged 12–25 (1.8–5.9 per 1,000 people) is higher than state averages. Importantly, three federally recognized tribes are served by this program. Counties in which American Indian tribes are located consistently experience the highest number of prescriptions per person for controlled substances.

INTERVENTION/PROGRAM MODEL

The HOPE Consortium created a recovery-oriented system of care (ROSC) that focuses on health, wellness, and recovery from substance use disorders. The ROSC infrastructure provides individualized, person-centered, strength-based services. Recovery coaches help individuals bridge the gap between clinical treatment and sustainable recovery outside the clinical setting, existing between the support group sponsor and the addiction counselor to connect treatment to enduring recovery.

ROLE OF AMERICORPS MEMBERS

During their term of service as recovery coaches, members work with individuals and groups; coordinate community-based recovery/education events; and recruit, manage, and serve alongside a minimum of 100 volunteers to promote recovery-centered activities in the community. To support long-term recovery, AmeriCorps members work one-on-one with self-identified individuals seeking recovery from a substance use disorder, developing a recovery service plan, providing sober companionship, listening to concerns, helping eliminate potential obstacles to recovery, connecting with support services, and sharing information about the recovery process.

MEASURES

The program measures an individual's progress by assessing each goal from his or her recovery service plan, which is tailored to each individual.

Program measurements include:

- Output – Clients with recovery service plans
- Outcome – Clients with progress toward one recovery service plan goal

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MARY HITCHCOCK MEMORIAL HOSPITAL

NEW HAMPSHIRE

ABOUT THE GRANTEE

The Mary Hitchcock Memorial Hospital (MHMH) is a non-profit, academic health system, serving a population of 1.9 million people. MHMH's community health team works with community partners to build their capacities, programs, and policy approaches regarding substance use, mental health, aging, oral health, obesity, and other needs.

FUNDING LEVEL

Total 2018: $515,109

- **Federal 2018:** $221,279
- **Applicant Match**: $293,830
    - **Public:** $80,000
    - **Private:** $213,830

Federal 2017: $221,279

AMERICORPS MEMBERS

Funding Year 2018: 16 full-time members, 16 MSYs*

Funding Year 2017: 16 full-time members, 16 MSYs*

*Member Service Year (MSY): One MSY is equivalent to one full-time AmeriCorps member serving 1,700 hours.

COMMUNITY PARTNERSHIPS

Southern New Hampshire Health, Strafford County, and Audrey and Theodor Geisel School of Medicine at Dartmouth

SETTING

Health care systems

BACKGROUND

New Hampshire's system of care for people with opioid use disorders is limited, particularly for economically disadvantaged individuals. In 2015, the New Hampshire Medicaid Office found that almost one-third of Medicaid beneficiaries had a need for substance use or behavioral health services. Additionally, MHMH's target population is less capable of routine preventive, primary, and ambulatory behavioral health care, resulting in poorly coordinated care. Historically, New Hampshire has had high rates of substance misuse, but over a three-year period, drug-related deaths increased from 14.5 per 100,000 in 2013 to 35.9 per 100,000 in 2016.

INTERVENTION/PROGRAM MODEL

AmeriCorps members serve as either community health workers (CHWs) or substance use recovery coaches, and work with Medicaid beneficiaries who have opioid use, substance use, and/or co-occurring substance use and mental health disorders. AmeriCorps members participate in care coordination teams, implementing two approaches: critical time intervention, an evidence-based approach to improving outcomes for persons transitioning from hospitalization to community-based care systems, and enhanced care coordination, which provides wraparound, multi-organization coordination of care to patients with complex non-clinical needs or symptoms escalating to higher levels of crisis.

ROLE OF AMERICORPS MEMBERS

The program assigns AmeriCorps members to host site care coordination teams. Teams are activated when patients:

- Experience a crisis event, such as emergency department visit or hospitalization
- Face non-clinical issues that could become barriers to care, such as a patient receiving notice they have a pending eviction concern
- Have difficulty with transportation or other needs
- Miss two or more appointments

CHWs will work with an estimated eight patients at a time, serving an estimated 30 patients during the member service year.

MEASURES

The program's overall intent is to increase engagement in primary and behavioral health care for patients referred to the care coordination team. A database created by the grantee collects this information therein notifying AmeriCorps members when a patient engages in these intended services.

Program measurements include:

- Output – Number of individuals receiving CHW services
- Outcome – Number of individuals increasing use of primary and behavioral health care

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MERCY HEALTH

OHIO

ABOUT THE GRANTEE

Mercy Health Hospitals of Ohio conducts this project in six emergency departments. In 2015, Mercy Health's Behavioral Health Institute implemented a plan to deliver Screening, Brief Intervention, and Referral to Treatment (SBIRT) services to adult patients presenting in the emergency department. The purpose of this plan is to increase the number of patients receiving education and being linked to services that address mental health and substance abuse.

FUNDING LEVEL

Total 2018: $200,101

- **Federal 2018:** $149,280
- **Applicant Match**: $50,821 (Private funding and in-kind match from Mercy Health Foundation)

Federal 2017: $138,001

AMERICORPS MEMBERS

Funding Year 2018: 10 full-time members, 10 MSYs

Funding Year 2017: 10 full-time members, 10 MSYs

**Member Service Year (MSY): One MSY is equivalent to one full-time AmeriCorps member serving 1,700 hours.*

COMMUNITY PARTNERSHIPS

N/A

SETTING

Emergency departments

BACKGROUND

In 2015, 82 percent of all Ohio overdose deaths were due to opioid overdose, the highest percentage of any U.S. state. Mercy Health emergency departments in the targeted area have experienced much higher mortality rates than the national average due to the high rate of opioid use and low access to organized systems of care.

INTERVENTION/PROGRAM MODEL

The expected outcome of this program is to improve patients' knowledge of opiates and substance use disorders, and to provide access to treatment and social services. Alongside the hospital's SBIRT technician, AmeriCorps recovery coaches deliver SBIRT services to every presenting individual in the emergency department. Through the presence of AmeriCorps, the hospital's capacity to complete screenings is increased. Recovery coaches help coordinate connections/referrals to services as well as help address barriers to care, such as insurance coverage or transportation. Members determine which interval follow-up is needed (i.e., weekly, monthly, etc.). The follow-up contact allows members to gather information about progress/connection to services which recovery coaches use to update an individual's medical record to help with measurement.

ROLE OF AMERICORPS MEMBERS

The primary role of the AmeriCorps member is to serve as a link between the initial health care/emergency department encounter and social/treatment services.

The member contacts treatment providers and supports the patient's attendance by finding a provider, verifying insurance, assisting with scheduling, and providing follow-up reminders. The member also helps overcome potential barriers such as finding transportation, addressing the costs of care, and applying for insurance.

MEASURES

AmeriCorps members use data from the electronic health record to capture the number of patient screenings in emergency departments.

Members collect information at the patient intake and at the six-month follow-up call to determine the decrease in substance use.

Program measurements include:

- Output – Number of service sites providing a minimum of 2,000 SBIRT screenings
- Outcome – Percentage of patients reporting a decrease in substance use from intake to six-month follow-up

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NEW YORK CITY OFFICE OF THE MAYOR – PEER CORPS

ABOUT THE GRANTEE

NYC Service, a division of the New York City Office of the Mayor, was formed to encourage service in New York City. For several years, NYC Service has operated multiple AmeriCorps programs including NYC Civic Corps, NYC VISTA, and City Services Corps.

NYC Service's mission is to promote volunteerism and help New Yorkers address New York's greatest needs. In 2017, the Mayor's office launched HealingNYC to address the pressing issue of opioid-related deaths through four goals: (1) preventing opioid deaths, (2) preventing opioid misuse and addiction, (3) connecting New Yorkers to effective treatment, and (4) reducing the supply of dangerous opioids. Peer Corps supports this government effort and specifically focuses on goal #3.

FUNDING LEVEL

Total 2018: $473,210

- **Federal 2018:** $294,000
- **Applicant Match**: $179,210 (Public funding and in-kind contributions)

AMERICORPS MEMBERS

Funding Year 2018: 20 full-time members, 20 MSYs*

**Member Service Year (MSY): One MSY is equivalent to one full-time AmeriCorps member serving 1,700 hours.*

COMMUNITY PARTNERSHIPS

Bureau of Alcohol and Drug Use Prevention and Bureau of Children, Youth, and Families

SETTING

Homeless shelters, family resource centers

BACKGROUND

In 2015, 13.6 per 100,000 New York residents died from a drug overdose. The problem appeared to increase in 2016, when New York averaged three to four overdose deaths per day, with an estimated 80 percent of those involving an opioid.

Although young people represent a smaller percentage of opioid overdose deaths in New York compared to adults, young people are less likely to be offered medication-assisted treatment, limiting roads to recovery. To best fill this gap, Peer Corps focuses on two vulnerable populations: young adults and homeless adults.

INTERVENTION/PROGRAM MODEL

Peer Corps connects families with children ages 14-24 struggling with opioid addiction as well as homeless individuals struggling with opioid addiction to critical recovery supports to mitigate the potential for relapse or misuse of opioids. The long-term outcome this project aims to accomplish is to decrease mortality due to opioid overdose.

Emphasis on recruiting coaches with lived experience is a critical element of this project. Peer support workers use their lived experiences to engage, support, and coach people with opioid addiction, whose needs might not have been fully recognized or served by the traditional health care workforce, to facilitate recovery and reduce health care costs.

ROLE OF AMERICORPS MEMBERS

Members serving young adults conduct trainings for families on the risks and science of opioid addiction. Members assist families through community presentations (three to four per week), small group presentations (one to two per week), and one-on-one sessions on the phone or in person. Members also help families identify needs, strengths, challenges, and goals for youth (ages 14–24) struggling with or at risk of opioid addiction.

Members serving in shelters work daily with shelter residents both informally (community check-ins) and during weekly community meetings. Members provide peer support to residents struggling with opioid addiction based on resident needs. In addition, members assist residents with identifying needs, strengths, challenges, and goals. Members also monitor residents' progress of goals, help residents adopt positive health behaviors, and connect residents to critical support services.

NEW YORK CITY OFFICE OF THE MAYOR – PEER CORPS

NEW YORK

MEASURES

Training attendance logs track the number of individuals who receive recovery support trainings. The program uses pre- and post-tests to assess participants' increase in understanding treatments that reverse overdose/manage withdrawals and cravings.

Program measurements include:

- Output – Number of individuals who received recovery support trainings related to opioid addiction by Peer Corps members
- Outcome – Number of individuals who report greater understanding of treatments to reverse overdose or manage withdrawal and cravings
- Outcome – Number of shelter residents at risk of overdose connected to services outside of shelter

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POLICE ASSISTED ADDICTION AND RECOVERY INITIATIVE

MASSACHUSETTS

ABOUT THE GRANTEE

The Police Assisted Addiction and Recovery Initiative (PAARI) was founded in 2015 to help sustain the Gloucester ANGEL Program and help other law enforcement agencies establish and run similar pre-arrest programs that create stigma-free entry points to treatment and recovery programs. PAARI is a free service for any police department wishing to change the relationship between police and individuals affected by substance abuse. PAARI provides training and support, seed grants, 4 mg nasal naloxone (the opioid overdose reversal drug), connections to more than 300 treatment centers, staffing support, case management, a unified voice with the media and legislators, and a network of like-minded law enforcement agencies. Since 2017, this program has expanded exponentially to 256 law enforcement partners and 300 treatment partners across the country.

FUNDING LEVEL

Total 2018: $431,992

- **Federal 2018:** $283,980
- **Applicant Match**: $148,012
  - **Public:** $65,000 **Private:** $83,012

Federal 2017: $207,450

AMERICORPS MEMBERS

Funding Year 2018: 5 full-time members, 20 non-full-time members, 15 MSYs*

Funding Year 2017: 5 full-time members, 20 non-full-time members, 15 MSYs*

**Member Service Year (MSY): One MSY is equivalent to one full-time AmeriCorps member serving 1,700 hours.*

COMMUNITY PARTNERSHIPS

256 law enforcement agencies from 30 states

SETTING

Police departments

BACKGROUND

In 2012, Massachusetts experienced a significant increase in opioid overdoses and fatalities. From 2000 to 2011, Massachusetts averaged 548 opioid-related deaths per year. The rate of deaths continued to increase, and by 2016, Massachusetts experienced 1,979 opioid-related deaths per year, with more than five deaths per day. The opioid-related death rate in Massachusetts is more than double the national average, and an increase in fentanyl use is cause for greater concern. Drug overdose is now the leading cause of accidental death in Massachusetts. Although treatment services exist in this area, barriers include lack of 24/7 access to treatment, lag in wait times to enter treatment, limited insurance or financial means to pay, and stigma of seeking treatment.

INTERVENTION/PROGRAM MODEL

Launched on June 1, 2015, the ANGEL Initiative operates 24 hours a day, 7 days a week, inviting people seeking help for opioid addiction to present themselves to the Gloucester Police Department. Once there, they will be directly connected to detoxification, outpatient care, inpatient programs, and medically assisted treatment.

Most partners follow the Gloucester ANGEL model where individuals seeking treatment voluntarily self-refer to the safe/sanctuary police station, the Arlington Outreach model where individuals who have experienced an overdose are sought out and offered support, or some combination or variation thereof. PAARI's law enforcement programs address the primary barriers to treatment.

A police partner survey conducted by the Boston University School of Public Health in October 2016 determined that 75 percent of law enforcement partners operating a PAARI program rely on volunteers to help run the program and that with additional volunteers and more training and support, programs would be even more successful. Volunteers (or “angels”) primarily provide comfort and conversation to individuals seeking help in a police-based program.

POLICE ASSISTED ADDICTION AND RECOVERY INITIATIVE

MASSACHUSETTS

ROLE OF AMERICORPS MEMBERS

The five full-time members serve as program coordinators. The primary objective of the program coordinators is to build the capacity of the programs and law enforcement agencies to reduce barriers, increase access to treatment, and increase awareness and participation in PAARI programs.

The 20 part-time members serve as recovery coaches at police departments across Massachusetts. Recovery coaches' goals include:

- Using the Screening, Brief Intervention, and Referral to Treatment approach with individuals seeking recovery services
- Accompanying police officers to home outreach visits 12–24 hours following a non-fatal overdose to offer treatment and support
- Providing case management and coaching to program participants when they return to the community after their detox and/or treatment program
- Recruiting, training, and supervising volunteers who provide additional recovery support to participants on a more casual basis

MEASURES

The program uses both paper and electronic intake forms and interaction logs to track all individuals who received information, coaching, or treatment referrals. These logs track personal identifiers, demographic information, and next steps.

PAARI also uses a pre- and post-organizational assessment tool to determine the member's impact on the department and the program's effectiveness.

Program measurements include:

- Output – Number of unique individuals with substance use disorder (SUD) or family members receiving treatment, support, or information
- Outcome – Number of unique individuals with SUD requesting and receiving referrals to treatment

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READING & MATH, INC. – RECOVERY CORPS

MINNESOTA

ABOUT THE GRANTEE

Reading & Math, Inc., (RMI) formed in 2010 with the purpose of replicating and scaling AmeriCorps program models to address state priorities. RMI operates Reading Corps, Math Corps, and Opportunity Corps. Across all programs, RMI manages more than 2,000 members and serves 37,900 individuals at nearly 800 sites in four states. The Recovery Corps program partners with three local service providers to enhance recovery program processes, reduce relapse, and initiate short-term recovery for sobriety and career success.

FUNDING LEVEL

Total 2018: $789,503

- **Federal 2018:** $600,000
- **Applicant Match**: $189,503
  - **Public:** $34,000
  - **Private:** $155,503

Federal 2017: $300,000

AMERICORPS MEMBERS

Funding Year 2018: 30 full-time members, 30 MSYs*

Funding Year 2017: 15 full-time members, 15 MSYs*

**Member Service Year (MSY): One MSY is equivalent to one full-time AmeriCorps member serving 1,700 hours.*

COMMUNITY PARTNERSHIPS

St. Paul Sober Living, Minnesota Recovery Connection, Peers Enjoying a Sober Education (P.E.A.S.E.) Academy

SETTING

Sober housing, recovery centers, and recovery high schools

BACKGROUND

The number of Minnesotans who died from opioid overdoses between 1999 and 2014 grew by 500 percent, and opioid-related deaths are now the leading cause of drug-related deaths in Minnesota. Minnesota has many resources to support those in recovery, but the capacity of those resources is limited. Many organizations provide basic support such as housing, and drug counseling, but they are unable to provide additional services that increase the likelihood of a successful recovery like individualized coaching and employment support. In a national summit on how AmeriCorps members could meet the needs of the drug recovery community, representatives from recovery-based organizations in the Twin Cities metro area expressed an interest in additional resources to assist people in recovery as they reintegrate into the community—specifically calling out the need for non-clinical coaching support around life skills and employment.

INTERVENTION/PROGRAM MODEL

Clients' recovery coaching takes place in three settings: sober housing, recovery centers, and recovery high schools. The focus of coaching is to improve individuals' health, home, purpose (e.g., conducting meaningful daily activities, such as working or volunteering), and community (e.g., healthy social networks). Services including screening, skills training, service projects, and individualized coaching support.

ROLE OF AMERICORPS MEMBERS

Each AmeriCorps member provides recovery coaching to 20 clients/participants for at least six months. This coaching includes group skills training on topics such as responsibility taking, goal setting, and career assessment as foundations for a sober life. In addition, recovery coaches provide training related to employability and job seeking. Clients also identify their interests and participate in service projects led by AmeriCorps members. Finally, clients receive individualized coaching to problem solve challenges faced during recovery, such as navigating social settings.

MEASURES

RMI measures outcomes by using the nationally standardized Recovery Capital Index. Clients receive scores on a scale from 1 to 5 in the following areas: family/social capital (family, friends, community relationships), personal capital (basic needs, values, knowledge), community recovery capital (attitudes/policies/resources related to addiction and recovery), and cultural capital (beliefs, social attitudes). The program measures these scores at the beginning of service provision in regular intervals, as services are provided, and upon completion of services.

Program measurements include:

- Output – Number of individuals who begin receiving recovery coaching
- Outcome – Number of individuals who report an increase in recovery capital

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RIO ARRIBA COUNTY – RIO ARRIBA COUNTY II

NEW MEXICO

ABOUT THE GRANTEE

Rio Arriba County Department of Health and Human Services (HHS) has submitted for a planning grant. The state of New Mexico has operated Rio Arriba HHS for more than 20 years. The agency provides case management, jail re-entry, jail diversion, and counseling services. Rio Arriba County HHS managed an AmeriCorps VISTA grant this past year and provided VISTA placements for three years.

FUNDING LEVEL

Total 2018: $39,000

- **Federal 2018:** $30,000
- **Applicant Match**: $9,000 (all public funding)

Federal 2017: Did not apply

AMERICORPS MEMBERS

N/A

COMMUNITY PARTNERSHIPS

Northern New Mexico College

SETTING

Clinics, hospitals, community mental health centers, treatment centers, and detention centers

BACKGROUND

Rio Arriba is a rugged, rural/frontier county the size of Connecticut and the only county in the U.S. zoned solely for agricultural pursuit.

For two decades, Rio Arriba has had one of the highest rates of heroin overdose deaths in the nation. Although the community of Rio Arriba has worked to resolve this crisis, distance and a limited health care workforce have prevented the delivery of sufficient services to meet the need.

The principal focus of this application is to plan a program to help train and certify AmeriCorps members to increase the health service agency workforce.

INTERVENTION/PROGRAM MODEL

This grant aims to bring together community stakeholders interested in identifying areas in which support is needed for those affected by the opioid crisis. The focus is to increase the number of certified peer support workers, community health workers, certified nursing assistants, and medical coders.

This AmeriCorps program plans to partner with Northern New Mexico College to train members for one year in health care roles. This experience will help members obtain future employment in similar positions after their term of service, therein leading to an expansion of the necessary workforce in this locale.

Also, with the support of AmeriCorps members, the Rio Arriba County sheriff can provide pre-booking diversion programs easing the burden on jails and law enforcement while improving capacity for treatment.

ROLE OF AMERICORPS MEMBERS

Once trained in the necessary fields, members will engage individuals who recently came in contact with law enforcement due to a drug-related matter. In this capacity, members can educate individuals on the use of naloxone, a medication used to treat opioid overdoses, and on how to access further treatment.

In the medical setting, members trained in billing and coding will increase the capacity of treatment providers to process billing, allowing more individuals to access care using Medicare or Medicaid.

MEASURES

As it is still in the planning phase, this grant has yet to yield any outcomes or outputs. However, the grantee envisions this program having the following impact on the community:

- Health industry workforce development
- Meaningful work for recovering addicts
- Environment conducive to recovery
- Educated and engaged employers

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RURAL HEALTH NETWORK OF SOUTH CENTRAL NEW YORK – COMBATTING THE OPIOID EPIDEMIC – FORMULA SUBMISSION

NEW YORK

ABOUT THE GRANTEE

Rural Health Network was incorporated in 1998 to advance the health and wellbeing of rural people and communities. It aims to meet the needs of those in rural areas by providing community health services, including health access and rural health planning, mobility management (transportation referral, public transit training, financial assistance), and a food and health network (a coalition supporting access to fresh, healthy, local food).

Rural Health Network has been an AmeriCorps grantee since 2008 and an AmeriCorps VISTA grantee since 2012. The Rural Health Network is in its ninth year of AmeriCorps programming, operating as an intermediary with host site partners.

FUNDING LEVEL

Total 2018: $401,836

- **Federal 2018:** $229,689
- **Applicant Match**: $172,147 (Program income, host sites, NYS Office of Rural Health, NYS Office of Alcoholism and Substance Abuse Services)

Federal 2017: $150,765

AMERICORPS MEMBERS

Funding Year 2018: 6 full-time members, 22 non-full-time members, 15.77 MSYs*

Funding Year 2017: 4 full-time members, 21 non-full-time members, 12.47 MSYs*

**Member Service Year (MSY): One MSY is equivalent to one full-time AmeriCorps member serving 1,700 hours.*

COMMUNITY PARTNERSHIPS

Mothers & Babies Perinatal Network, The Bridges Program, Family Counseling Services of Cortland County, Cortland Area Communities That Care, Broome County Promise Zone, Southern Tier AIDS Program, Tioga County Health Department, Alcohol and Drug Abuse Council of Delaware County, CASA-Trinity, United Way of Broome County

SETTING

Recovery centers and health networks, schools, and community centers

BACKGROUND

Heroin overdose is now the leading cause of accidental death in New York State. The opioid epidemic in New York worsened from 2010 to 2015, especially in upstate New York and rural areas.

INTERVENTION/PROGRAM MODEL

Interventions depend on the host site: school-based prevention may be taught throughout the year or may be a single presentation, community-based prevention education may be a single session, and community naloxone trainings are single training sessions. Assisting with recovery resource navigation involves individual assistance.

ROLE OF AMERICORPS MEMBERS

Members engage in administering:

- School-based prevention
- Community-based prevention
- Trainings on how to respond to opioid overdoses with naloxone
- Education and support to identify treatment services
- Support to those in recovery

MEASURES

This grantee hopes to impact the significant opioid epidemic in rural areas by using AmeriCorps members to increase the reach of services as well as knowledge about the dangers of opioids in the communities served. Tools used to measure these outcomes include attendance logs and self-reported information via surveys.

Program measures include:

- Output – Number of clients participating in health education programs
- Outcome – Number of individuals who self-report health improvements or positive behavior change

The preceding information was gathered from the grantee's application for federal funding. The descriptions provided do not represent the views of the Corporation for National and Community Service, AmeriCorps State and National, or Office of Research and Evaluation. The information provided does not constitute an endorsement of the grantee.

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