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RECOVERY COACHES

Not a sponsor and not a therapist: What do they do, where are they being utilized, are they effective?

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RECOVERY RESEARCH INSTITUTE

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Disclosures

I have the following relevant consulting and financial relationships to disclose:

- Co-founder / partner – Peer Recovery Consultants
- Scientific advisory board / stockholder – ViviHealth
- Scientific advisory board / stockholder – InnerWorld

What do recovery coaches do?

- Peer-driven mentoring, education, and support services delivered by people with lived experience
- Goal is to link to and supplement addiction treatment and mutual-help participation

Image courtesy NAMI N. Carolina

"A peer-helping-peer service alliance in which a peer leader in stable recovery provides social support services to a peer who is seeking help in establishing or maintaining their recovery."

SAMHSA
Substance Abuse and Mental Health Services Administration

What recovery coaches don't do

- Not sponsors
- Not aligned with any one therapeutic approach
- Don't diagnose
- Don't provide psychotherapy or treatment

https://www.recoveryanswers.org/media/meet-your-recovery-team-infographic/

Where are recovery coaches being utilized?

Hospitals

Detox Units

Supportive Housing

Outpatient Clinics

Recovery Community Centers

Certification landscape

Findings Certification Requirements

Certification is available in 48 states + DC

Certifying entities:

- 29 states: **private**; 16 states: public; 3 states: public/private
- 23 different **job titles** – All use peer or recovery or both; "Peer Recovery Specialist" most common

- Majority require **HS Diploma/GED** and passing an **exam**
- 13 states require **lived experience**
- Hours of **training & work experience** vary; MA requirements are above average

University of Massachusetts UMASS Medical School
commed.umassmed.edu

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Courtesy Mass.gov

Certification landscape

	NAADAC NCPRSS	MBSACC CARC
Education	High school diploma or GED	High school diploma or GED
Lived Experience	At least 2 years of recovery from lived experience in substance use and/or co-occurring disorder	Not applicable
Training	60 contact and training hours (CEs) of peer recovery-focused education and training. • At least 48 hours of peer recovery-focused education/training • At least six hours of ethics education and training and six hours of HIV/other pathogens education and training within the last six years. *1 hour of education/training = 1 CE; 1 quarter college credit = 10 CEs; and 1 semester college credit = 15 CEs.	60 hours in the four CARC domains and additional trainings: 1. Advocacy (10 hours) 2. Mentoring/Education (10 hours) 3. Recovery/Wellness Support (10 hours) 4. Ethical Responsibility (16 hours) Additional trainings: Cultural Competency (3 hours), Addictions 101 (5 hours), Mental Health (3 hours), Motivational Interviewing (3 hours)
Direct Practice	200 hours (volunteer or paid) of experience in peer recovery support environment (supervisor-attested)	500 hours of work experience in the four CARC domains, completed in the last 10 years
Supervision	Not applicable	35 hours of work experience (minimum of 5 hours per CARC domain), supervised by a trained Recovery Coach supervisor
Exam?	Yes	Yes
Recertification	20 hours of continuing education every two years, including six hours of ethics training. • Provide work history for the two years prior to renewal. • Self-attestation of ongoing recovery	30 contact hours of approved continuing education, approved by MBSACC, every two years

Courtesy Mass.gov

NAADAC
NAADAC.ORG
THE ASSOCIATION FOR ADDICTION PROFESSIONALS

National Association for Alcoholism and Drug Abuse Counselors (NAADAC), National Certified Peer Recovery Support Specialist (NCPRSS)

MBSACC

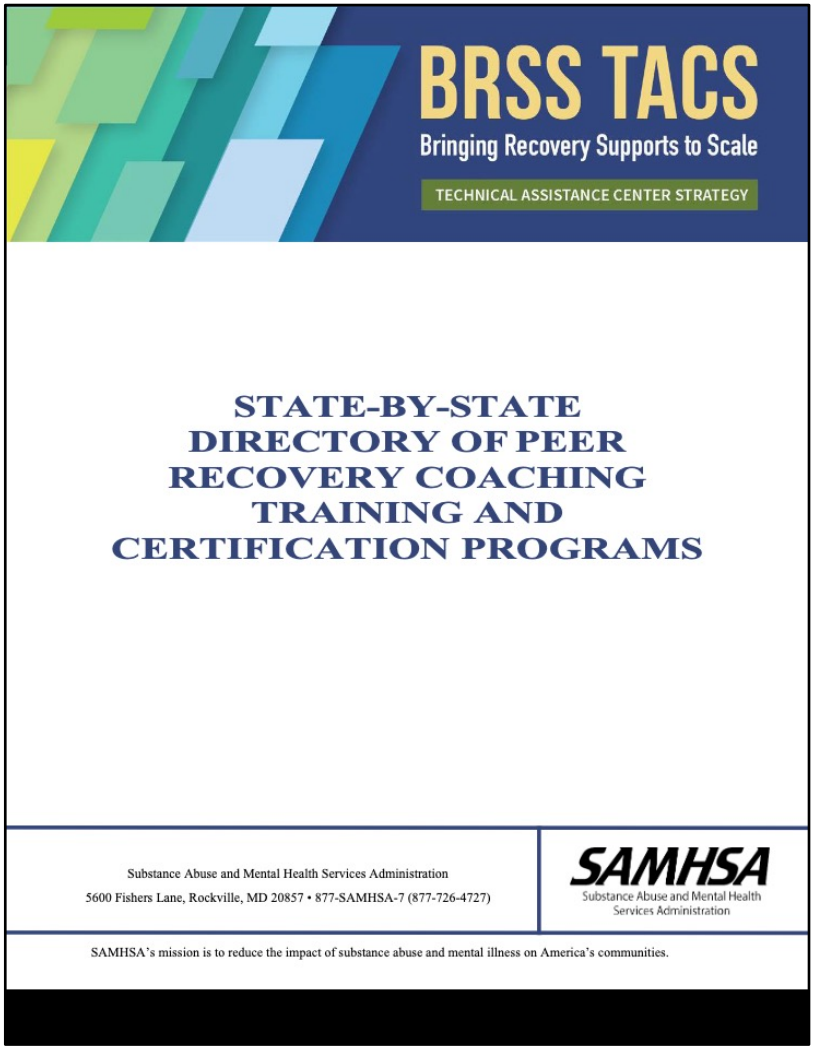
The Massachusetts Board of Substance Abuse Counselor Certification (MBSACC), Certified Addictions Recovery Coach (CARC)

CCAR

Connecticut Community for Addiction Recovery (CCAR)

Certification landscape

Find the report here



Studies to date

Search identified 31 studies from 1993-2023

Type of Study Design	Number of Studies N	Sample size Mean N (range, SD)	Mean Age (range, SD)	Mean % Female (range, SD)	Mean % Racial/Ethnic Minority (range, SD)	Longest Follow-Up * (Mean, range, SD)	Primary Drug of Focus				
							% Alcohol	% Mixed	% Opioids	% Stimulants	% Cannabis
Randomized Controlled Trial	7	M= 270.4 Range= 80 – 1,175 SD= 400.6	M= 42.1 Range= 37.9 – 56 SD= 6.3	M= 32.0 Range= 3 – 45 SD= 14.0	M= 52.9 Range= 20 – 86 SD= 31.1	M= 9.0 Range= 6 – 12 SD= 3.0	0	85.7	14.3	0	0
Comparative trial (non-randomized)	10	M= 590.5 Range= 18 – 2,706 SD= 853.3	M= 38.5 Range= 31.5 – 49 SD= 4.7	M= 54.9 Range= 38 – 100 SD= 26.4	M= 42.7 Range= 10 – 100 SD= 35.9	M= 9.9 Range= 0.25 – 41 SD= 14.5	0	70	20	10	0
Single Group (no comparison)	12	M= 708.1 Range=13 – 3,459 SD= 1,121.0	M= 38.7 Range= 26 – 52 SD= 8.8	M= 41.6 Range= 0 – 100 SD= 21.4	M= 61.7 Range= 24 – 100 SD= 26.8	M= 7.5 Range= 3 – 12 SD= 3.0	0	80	20	0	0

Nb. Follow-up times denoted in months

Studies to date

Wide range of...

- peer recovery support services studied
  - *e.g., recovery coaching, peer education, skills training*
- treatment intensities
  - *e.g., single-session interventions, mid- and long-term support*
- populations studied
  - *e.g., engaged in formal treatment/not, comorbidity, recently incarcerated*
- research settings
  - *e.g., inpatient detox, residential and outpatient treatment, primary care, harm-reduction programs*

Substance Use Outcomes

13 studies with substance use outcomes (6 RCTs)

- Generally positive outcomes, though some exceptions (Byrne, 2020; Winhusen, 2020; Hansen, 2022), and effect sizes modest
- Observed reductions in alcohol (Rowe et al., 2007; O'Connell, 2020), cocaine (Bernstein, 2005), multi-substance use (Rowe et al., 2007; Blondell 2008; Armitage, 2010; Ray, 2021; Ashford, 2021; Kelley, 2021; Crowthers, 2022, Park, 2023)
- Nb. Potential for reporting bias

Substance Use Disorder Severity

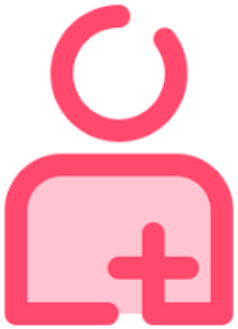
3 studies (1 RCT) reported substance use disorder severity – largely positive outcomes

- Trend reduced addiction severity in individuals receiving brief drug use intervention in primary care setting (Bernstein, 2005)
- Reductions in physical, interpersonal, and intrapersonal consequences + increases in impulse control and social responsibility in rural women with substance use disorder and HIV (Boyd, 2005)
- Increased likelihood of no health-related behavioral and social consequences of drug use following 6 months of peer coaching (Crowthers, 2022)

Treatment Linkage/Engagement

17 papers (5 RCTs) reported on linkage to treatment, treatment engagement, or medical readmission

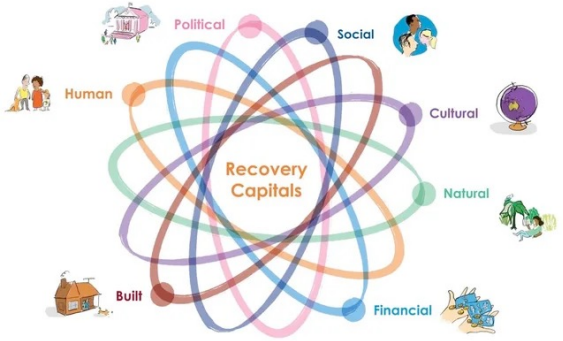
- Majority of findings positive or mixed (Klein, 1998; Byrne, 2002; Min, 2007; Blondell, 2008; Tracy, 2011; Wakeman, 2019; David, 2021; Watson, 2021; Kelley, 2021; Cup, 2022; Mills Huffnagle, 2022; Martin, 2023; Suzuki, 2023)
- Negative findings also reported (Winhusen, 2020)



Recovery Capital

6 papers reported on recovery capital and related measures

- Studies reported positive results on measures of overall recovery capital (Ashford, 2021), housing (Kelley, 2021; Hansen, 2022; Crowthers, 2022), and employment (Kelley, 2021; Hansen, 2022; Crowthers, 2022)
- Mostly positive results for social connectedness (Boisvert, 2008; Crowthers, 2022; Park, 2023), though Kelley found reduced social connections in their peer program for Native Americans living in Montana and Wyoming (Kelley, 2021)

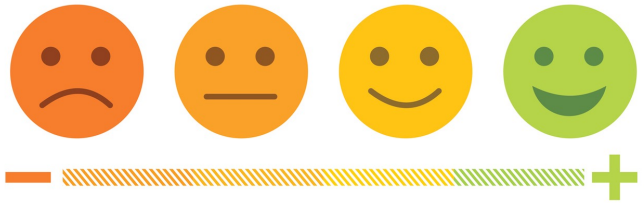


Courtesy Phoenix Australia

Affect

4 papers reported negative affect; none positive affect

- 3 showed peer supports reduced negative affect (Crowthers, 2022; Hansen, 2022; Park, 2023); 1 with mixed results (Park, 2023)
- 1 study with individuals with comorbid SUD and psychosis found peer support was associated with greater increases in negative affect relative to treatment as usual (O'Connell, 2020)



Courtesy Assoc. for Psychological Science

Quality of Life

2 papers reported on quality of life

- Boisvert et al. found no change in quality of life from baseline to 9-month assessment in individuals living in a therapeutic community (Boisvert, 2008)
- Ray et al. saw modest improvements in quality of life from baseline to 6- and 12-month follow-up, but these changes not significantly different to treatment as usual controls (Ray, 2021)

Conclusions

Encouraging findings across several domains:

- Strong evidence for peer support services on treatment linkage and engagement
- Effects on substance use also very promising
- Preliminary support for accrual of recovery resources (i.e., recovery capital)
- More work needed to see how peer supports influence affect and quality of life

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